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A Critical Look at Juvenile Offenders with Mental Illnesses:

What We Know, What We Don't, and Where We Go from Here

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Key Points

- The treatment of mentally ill juvenile offenders in Texas must be based on Texas-specific information: an estimated 38-42% of juvenile offenders suffer from some form of mental illness.
- Preliminary research suggests that diversions from incapacitation for mentally ill offenders cost less (as little as 50-80% less, on average) and provide more targeted treatment for mental illnesses.
- While more information is necessary, policymakers can use this survey of information to begin formulating more effective systematic responses to juvenile offenders.

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Introduction

Criminal justice, and specifically juvenile justice, is one of the most important functions of state government. We must ensure that the state executes its responsibility with best practices and accountability for juveniles, without unduly burdening taxpayers by the process.

That directive is critical with respect to the class of juvenile offenders inflicted with a mental illness. The last few decades have given rise to increased attention to this class of offenders, with a wide variety of ideas from different viewpoints on how to reform the system to better treat mental illnesses in juvenile offenders. Sometimes these ideas were accompanied by "zeal without the balancing effect of careful thought."[1]

The careful thought called on to temper zeal is found in evidence of both program- and cost-effectiveness. The incarceration of mentally ill juveniles in large, remote facilities in Texas and other states has come at a great cost and, more importantly, with high recidivism rates. Various programs designed to divert suitable mentally ill youths from incarceration have in many instances yielded promising results. However, a thorough examination is needed to develop a full picture of the relative cost-effectiveness of various diversion programs and identify the types of offenders for whom these programs are appropriate.

Two Challenges to Assessing the Current System

Two challenges make it difficult to have an accurate overview of the current system and its challenges. First, the national estimates of juvenile offenders with mental illnesses are imprecise and of limited value in discussions of individual state systems. Second, due to limitations of various screening methods and the fact that an individual's condition and need for treatment often changes, the prevalence rate cannot, on that basis alone, determine the extent of treatment required in an ideal juvenile justice system.

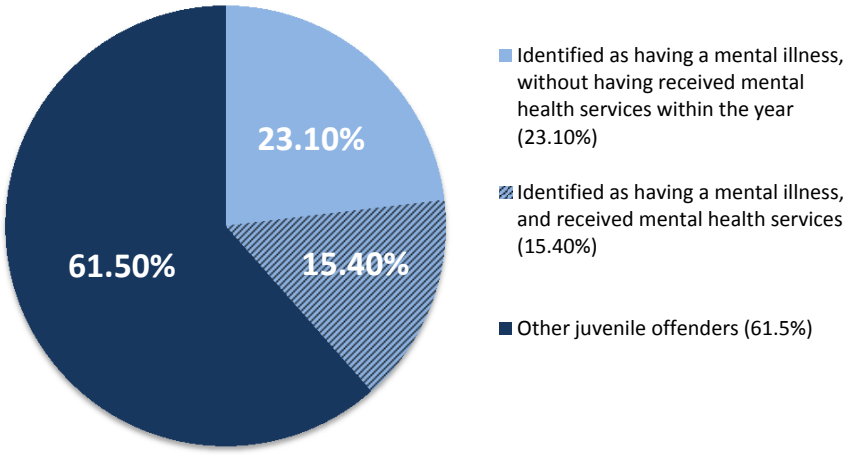
Accurate Estimates of Prevalence

Most studies and articles on this topic cite a general, nationwide statistic that more than 65-70 percent of juvenile offenders suffer from a mental illness,[2] which is sometimes proffered as fact, even though research on the prevalence of juvenile offenders with mental illnesses within the system has proven difficult to obtain. The Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice has questioned the precision of data on juvenile offenders suffering from a mental illness, stating that there are sampling problems and concerns about the instrument used and measurement of the results.[3] Others have noted research issues including few side-by-side comparisons to competing programs, randomized studies, or follow-up research to determine long-term outcomes.[4]

Rather than relying on national estimates, a figure specific to Texas can be found in the data released by the Texas Juvenile Probation Commission (TJPC) and the Texas Youth Commission (TYC), the two entities formerly responsible* for juvenile justice in Texas. The most recently released data from TJPC indicates that 38.5 percent of juveniles in TJPC custody in 2011 were identified as having a mental illness.[5]

* Effective December 1, 2011, TJPC and TYC merged into one entity, the Texas Juvenile Justice Department. When this paper discusses the future of juvenile justice in Texas, it will refer to that new agency, TJJD.

Juvenile Offenders in TJPC Custody (FY 2011)



This proportion follows 10 years of consistently rising rates of juvenile offenders with mental illnesses, between fiscal years 2001 and 2011. It is possible, as TJPC suggested, that the rising figures are due to departmental gains in reporting and screening for mental illnesses.[6] Even so, the rates reported by TJJD in the future should continue to be monitored to accurately assess the reason for the increases.

For those offenders committed to TYC's custody, the rate is a bit higher, but has remained consistent for the past few years: in fiscal year 2006, 41 percent of those committed to TYC for a felony were identified as having a mental illness, while 42 percent of those committed for a misdemeanor suffered from a mental illness.[7] In the 2010 fiscal year, TYC reported that 42 percent of those in its custody had a serious diagnosis of a mental illness.[8]

Because these rates are lower than the national estimate heavily relied upon, it is important to assess the accuracy of these figures, to determine whether Texas is underestimating the prevalence of juvenile offenders with a mental illness. Our examination of the definition of mental illness used by the Texas juvenile justice agencies shows that these rates can be relied upon as a more accurate estimation of the incidence of mentally ill juvenile offenders.

First, any study purporting to determine the incidence of mental illness will necessarily hinge on what disorders are, or are not, included in the definition of mental illness. For example, the National Center for Mental Health and Juvenile Justice conducted a study that initially found that 70.4 percent of juvenile offenders in their sample suffered from a mental illness. After removing conduct disorders* and substance abuse disorders from the study, however, the rate dropped to levels near that of Texas' data: under this definition, only 45.5 percent of juvenile offenders were considered to have a mental illness.[9] This methodology is commensurate with current practice in the Texas juvenile justice system. TJPC recognizes 95 designated mental illnesses, including a general "mood disorder," but not conduct disorder or substance abuse.[10]

Second, beyond the designated mental illnesses recognized by TJPC, the agency further classifies a juvenile offender as having a mental illness if the juvenile was registered with their community mental health department, started the Special Needs Diversionary Program (SNDP),† reported starting a different mental health program, started a mental health placement within 91 days of starting supervision with TJPC, or simply indicated an affirmative response to the mental health needs query on their monthly data extract.[11] This is

* The study noted "questions" raised as to the inclusion of conduct disorders in the definition of mental illness for this purpose, as criteria used to identify a conduct disorder are very similar to characteristic of delinquent youth in general. In fact, the DSM-IV defines a conduct disorder as "seriously misbehaving," in ways that may be "belligerent, destructive, threatening, physically cruel, deceitful, disobedient, or dishonest." The confluence of this rather imprecise definition with criminal behavior, generally, suggests that it may be best left out of the definition of mental illness for juvenile offenders.

† SNDP is a probationary program for juveniles with mental illnesses, discussed on pages 14-15.

a broad definition, including almost any contact with any mental health treatment or program, as well as self-reported mental health issues, whether the mental illness was confirmed or resolved through treatment. TJPC's measurement of mental illnesses, then, is more likely over-broad rather than under-inclusive, which further insulates the department's estimations of mentally ill juvenile offenders from arguments that it understates the issue.

These definitional variances have had a direct effect on the study and analysis of juvenile offenders with a mental illness. Because Texas' standards include a more precise definition of mental illness while casting a wide net to include all juveniles with mental health system contact or self-perception of a mental illness, Texas' rates of 38.5 to 42 percent probably present an accurate picture of the prevalence in Texas.

More Study is Needed to Compare Prevalence and Treatment Rates

The percentage of youths who exhibit some current or prior indication of mental illness is not necessarily commensurate with the percentage of youths that should be receiving specialized mental health treatment in an ideal juvenile justice system. Dr. Thomas Grisso wrote that, "most experts recognize that it is not necessary and is probably unwise for the juvenile justice system to translate the published prevalence rates into a policy that seeks treatment for two-thirds of the youths in its custody."[12]

TJPC stated that 40 percent of those identified as having a mental illness by TJPC actually received mental health services.[13] More research is needed to determine how many juveniles have a current unmet need for treatment and what percentage may no longer be experiencing symptoms of a severity that requires medication or psychological counseling, the two primary forms of mental health treatment.

Furthermore, TJPC did not identify the reasons why the other 60 percent did not receive treatment. However, the reasons given for why otherwise qualified juveniles did not receive treatment under SNDP included "lack of space in the program, juvenile or parent refusal to participate in the program, insufficient time remaining under juvenile court jurisdiction to allow for completion of the program or the juvenile's placement or commitment to TYC."[14] These reasons may shed light on the rate of mental health treatment systemwide.

For these reasons, a more detailed analysis of the offender population that goes beyond overall prevalence rates is needed to determine both proper treatment rates and the efficient allocation of treatment resources.

An Overview and Evaluation of the Current Institutional System

The Process in Place: The Initial Screening

Texas currently screens juveniles entering the justice system to determine the presence of a mental illness. Mental health screenings, generally, identify those juveniles with indicators of a possible mental illness and those that need immediate attention due to an urgent mental health need, such as those juveniles that pose a risk to themselves or others, or those suffering from acute distress, medication interruption, or withdrawal from a substance addiction.

In Texas, screening takes place at the time of the juvenile's first contact with TJPC. In 2001, the Texas Legislature mandated the use of a mental health screening instrument.[15] Under this directive, TJPC selected the second version of the Massachusetts Youth Screening Instrument, or the MAYSI-2. This test is comprised of 52 questions, in a self-report, yes-or-no format, which seeks to identify potential mental health issues or suicide risks.* The test takes about 10 to 15 minutes to complete, and can be administered by agency staff. The test is currently administered upon each referral to a county probation department, regardless of the length of time from the last screening or prior information in the file.

When a juvenile is deemed "screened in" under the screening instrument, this only means an indicator of possible mental health issues has been identified. Screening instruments are not able to diagnose a mental illness or provide any certainty about the mental state of the juvenile. Instead, this limited scope means that any determination that a juvenile actually has a mental illness requires further evaluation and testing for mental illnesses.

After being "screened in" under the MAYSI-2, the test is either readministered, to confirm a positive screening, or the juvenile is referred to a mental health provider to determine whether further mental health intervention is required.[16] If either resource indicates the need for treatment, then the juvenile is referred to a mental health professional or a physician.[17]

*The MAYSI-2 is not the only screening instrument available. The Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice has an exhaustive listing and description of all of the screening instruments available at https://www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf. However, there is not enough data available to determine whether the adoption of another instrument in Texas is warranted at this time.

Texas is one of 42 states in which at least one juvenile justice agency has adopted the MAYSI-2[18] and modifications have been made to improve its administration in Texas. There are two key points regarding the administration of this assessment that are critical to understanding how Texas currently screens youths.

First, there is evidence that the MAYSI-2 has an effect on both juveniles and detention center staff, merely through the act of requiring the juvenile to complete a screening instrument. A Pennsylvania study that compared juvenile detention centers before the use of the MAYSI-2 and after found that centers used fewer restraints and seclusions, peer-on-peer assaults dropped, and suicide watches increased by 20 percent—a result of increased staff awareness of suicide risks, which results in an increased ability to prevent suicidal events.[19]

The study's authors theorized that the screening increases staff knowledge about each juvenile's mental state and needs, which can prepare them to react and respond in a more organized and sensitive way. Furthermore, juveniles asked about their moods and emotions may feel less threatened and more cared for.[20] Either way, the information from the screening, even if never used in any other way, may have intrinsic effects within a facility.

Second, Texas has successfully modified the way the MAYSI-2 is scored to ensure it is not screening in juveniles unnecessarily. The main criticism levied at the MAYSI-2 is that its scope is too broad. Because the MAYSI-2 does not include questions regarding past mental health history or other risk factors, but rather focuses on present-day thoughts and feelings, it is possible that it is not an accurate picture of mental health. Given that the juvenile is being asked about their mental health on a very stressful, emotional day—a juvenile's contact with law enforcement or the criminal justice system—if the test results are not carefully filtered, it may sweep up non-mentally ill juveniles in its screening.

For example, the Justice Research Center studied the use of the MAYSI-2 in Florida, and determined that an affirmative answer to one question—"Have you ever in your whole life had something very bad or terrifying happen to you"—triggered a referral for further mental health examinations when the test is administered according to the standards provided by the authors.[21] Furthermore, researchers in Pennsylvania found that "in many cases the clinical consultation would have resulted in the advice that no treatment is necessary."[22]

Because of the potential over-sampling under the MAYSI-2, Texas implemented slightly stricter guidelines for determining whether a score on the MAYSI-2 qualifies the juvenile for a referral for further examination. The test is scored by tallying the "yes" answers in six categories, or subscales, and those affirmative answer totals fall into a "caution" scale, or a more serious "warning" scale. Under Texas' standard for applying the MAYSI-2, a juvenile is referred for further evaluation or treatment if the juvenile received two or more "warnings" across the six subscales, or four or more "cautions," or a "warning" on the suicide ideation scale.[23]

As a result, in the 2010 fiscal year, 18 percent of juvenile offenders screened using the MAYSI-2 were recommended to receive further evaluation.[24] This is commensurate with early years of use of the MAYSI-2, in which TJPC flagged 18 percent of those screened for further referral in 2004,[25] and 19.5 percent in 2002.[26] These proportions are well under the number of juveniles identified as having a mental illness by TYC or TJPC.

However, this does not necessarily present an issue in the mental health screening system. As Dr. Grisso noted, comparisons of prevalence rates calculated on the basis of initial screenings with the percentage of those in treatment must be tempered by the realization that the screening does not necessarily indicate that the juvenile is"seriously in need of psychiatric treatment,"[27] and further that treatment rates equivalent to published prevalence rates are neither "necessary" nor "wise."[28]

Therefore, to accurately assess the screening and identification process in TJPC, TJJD should make efforts to determine the overlap (or lack thereof) between those individuals flagged by MAYSI-2 and those identified as being mentally ill. This would prove instructive in evaluating both the MAYSI-2 and TJJD's performance.

The Process in Place: Treatment During Incarceration

Juveniles in state lockup facilities may receive mental health treatment while in state custody. Prior to 2007, TYC used a treatment delivery model, "Resocialization." Under this program, youths at most facilities received "basic treatment" services, including "psychiatric and psychological care and adaptations and modifications of the basic program."[29] However, youths at Corsicana and Crockett with "more serious" diagnoses were permitted to receive the full "Mental Health Treatment Program," with both more intensive and specialized treatment.[30]

In 2007 TYC initiated a new program for institutional treatment called CoNEXTions in response to widespread criticisms of previous TYC practices.[31] CoNEXTions includes a specialized treatment program for mental health, and expanded treatment for juveniles by providing protective hospital-like settings, residential treatment centers, and psychiatric and psychological services at all TYC facilities.[32] TYC provides group programming, therapy, and behavioral modifications through this program.[33]

Much less is known about the treatment of mentally ill youths entering county-run post-adjudication facilities and non-secure facilities in which juvenile probation departments place youths. Given that more than 10,000 youths enter these facilities annually, many more mentally ill youths likely enter these facilities than TYC, though the turnover is much greater, with an average stay of 87 days.[34] No statewide data is available on the percentage of youths entering juvenile detention who have an indicator of mental illness or their treatment. Another segment of youths are placed in residential facilities other than county-run post-adjudication facilities at the expense of juvenile probation departments, which are non-secure facilities mostly run by non-profits and overseen by the Department of Family and Protective Services because they also receive youths from the child welfare system. These facilities are typically far less institutional than county-run post-adjudication centers. Statewide data is also lacking on the share of youths placed in these facilities that have an indicator of mental illness.

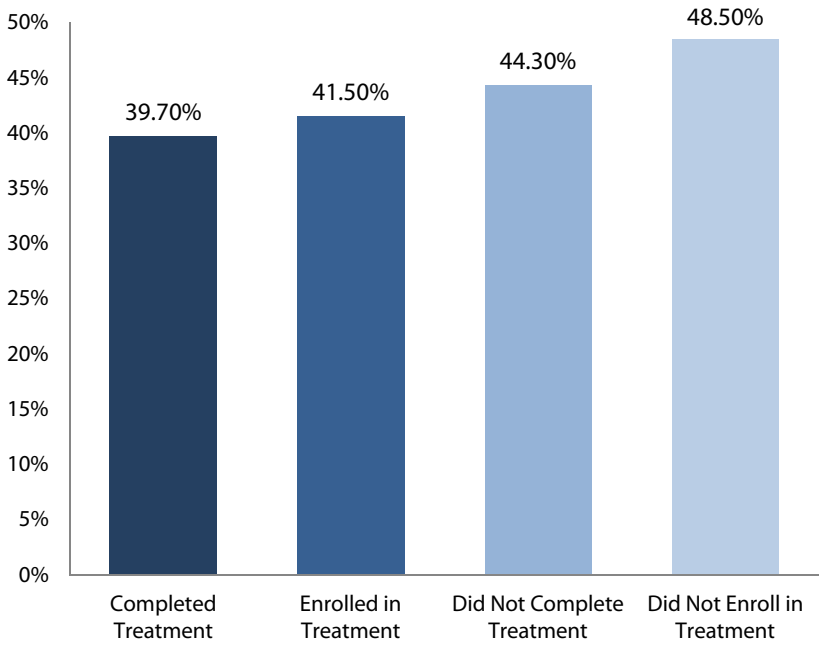
Another gap of knowledge in the current system is the limited data available concerning what level of supervision and treatment mentally ill youths receive upon reentry from detention, county post-adjudication facilities, placement in non-secure residential facilities, and state lockups.

Current Treatment Outcomes

To evaluate whether the state's current treatment of juvenile offenders with a mental illness is effective, it is helpful to first look at past outcomes. In 2005, TYC provided treatment under the Resocialization program, a specialized treatment program, to 251 youths out of 783 who were identified as needing mental health treatment.[35] Out of those 251, only 94 completed treatment.[36]

From data released in 2007, the recidivism rates between those offenders who did receive treatment and those who had a mental health need, but did not receive treatment, are only slightly better [see graph]. Those both enrolled and completing treatment had re-incarceration rates only slightly lower than those not enrolled and not completing treatment. Furthermore, those juveniles with a mental illness issue who did not receive treatment recidivated at about the same rate as all youth leaving TYC in that time period, a rate of 47.2 percent.[37]

Three-Year Reincarceration Rate Comparison



And in one category, the mental health treatment appeared to have almost a negligible effect. After three years, the proportion of youth who had been enrolled in treatment, but had not completed it, and were rearrested for a violent offense, was 18.2 percent. Those who had completed treatment were rearrested for violent offenses at a rate of 17.7 percent.[38] An effective treatment for mental illness—even if not completed—would, at the very least, not increase the risk of recidivism for violent offenders.

In order to determine whether the switch from Resocialization to CoNEXTions was worth the costs involved, it would be beneficial to compare recidivism rates for youths who were treated under the new program. Of the 149 youth in state custody identified as needing specialized mental health treatment, 97 percent were enrolled in mental health treatment in 2010.[39] Of these youths, only 19 percent completed the mental health treatment, although TYC stated that 90 percent of those youths "made a positive transition to other placements."[40]

Beyond that information, TYC only released data stating that those who entered treatment under the CoNEXTions program are 6.3 percent less likely to be rearrested for a felony or misdemeanor, 16.6 percent less likely to be rearrested for a violent offense, and 9.4 percent less likely to be reincarcerated.[41]

These rates are in comparison to other youths with mental health needs that did not enter treatment. Unfortunately, we do not know at what rate those youths recidivate, to determine whether these percentage decreases in recidivism rates, which refer to these other unreleased recidivism rates, indicate effective treatment.

However, if the recidivism rates for youths who did not enter treatment were comparable to the rates in 2007, then the CoNEXTions program would only have reduced the rate of reincarceration from 48.5 to 39.1 percent. This suggests little improvement for mentally ill youths receiving treatment within state facilities.

In addition, TYC released information comparing recidivism risks for youths in high-need mental health programs and medium-need mental health programs.[42] However, this data is not sufficient, as it not only statistically controls for "characteristics of the youth that are related to recidivism," but also again presents the information in the form of a reduction of risk, without the underlying data to determine whether the reduction of risk is significant or not.

Given the costs involved with incarceration generally, which in 2010 at a TYC secure facility averaged $359 per juvenile, per day,[43] it is necessary to determine whether the treatment effectiveness provides any information to justify that price tag. The information released by TYC does not present adequate, evaluative data to answer that question. The new agency should release outcome data for its current treatment programs for mentally ill youths beyond the decreased risks previously released, and with the underlying data clearly indicated.

With regard to youths entering county post-adjudication facilities, no statewide data is available on the percent of those who are mentally ill, the percent of these offenders who receive treatment and the outcomes for these mentally ill youths, such as recidivism and positive metrics such as subsequent educational participation and achievement. Thus, there is no baseline with which to compare post-adjudication facilities (with or without treatment) as an intervention for mentally ill youths versus various diversion programs.

TJPC stated that recidivism rates amongst juvenile offenders with a mental illness are 50 percent higher than non-mentally ill juvenile populations, pointing to 2008 recidivism rates of non-mentally ill offenders who reoffended with a felony or Class A misdemeanor at a rate of 26 percent after one year.[44] Mentally ill offenders, on the other hand, re-offended at a rate of 38 percent.[45]

This information, however, does not provide a complete picture. The "gold standard" for recidivism rates tends to be a three-year, reincarceration rate, as those rates provide long-range data on non-trivial justice system involvement. Without information on the difference between mentally ill youths and non-mentally ill youths according to this same standard, there is no way to accurately evaluate this rate. And thus, even if we had more specific totals of state expenditures on treatment for mentally ill juvenile offenders, it would be difficult to determine if taxpayers are getting their money's worth.

Existing Funding

In 2010, TYC spent an average of $359.58 per youth per day, which equates to $131,247 per youth per year for those in state institutions.[46]

In the probation context, the average cost of basic probation per day per youth in Texas is $17.25, which equates to $6,296 per year.[47] Also, TJPC received $3.95 million over the 2010-11 biennium to fund the aforementioned SNDP.[48] This

program is open to juvenile offenders under particular standards, including an Axis I Diagnosis.

Moreover, funds from several different grant programs are used to an extent that cannot be determined on mental health treatment or programming that may impact mental health issues. For instance, local probation departments may use state funds appropriated for basic probation or community corrections to fund rehabilitation and treatment facilities, including therapies and mental health care.[49] It is unknown the proportion of these funds used for these purposes, and the range of programs offered to juveniles on deferred prosecution and probation supervision participated in 2009-10 including anger management, counseling services, cognitive behavioral services, animal and equine therapy, life skills, mental health courts, and general mental health programs—among others.[50] Further, local juvenile probation departments placed 336 juveniles into specific mental health-related residential facilities in 2009-10.[51]

In the 2010-11 biennium, an unknown portion of funds from Grants U and X, which together totaled $6,901,835, appropriated for misdemeanor offenders no longer eligible for TYC Commitment, were also spent on programs impacting mental health—including counseling, cognitive behavioral therapies, life skills, mental health evaluations and assessments, wrap-around programs, and a variety of other programs—as part of the intensive community based programming.[52]

Other grants for "enhanced community-based services," (totaling $8.7 million statewide)[53] and the "community corrections diversion" grant (totaling $50 million in the 2010-11 biennium)[54] could also include mental health treatment funding. For instance, 10 departments requested $1,368,872 for mental health treatment out of Grant C, the community corrections diversion grant, in 2010, and $699,034 in 2011 by seven counties.[55] Yet other Grant C funds were used to place juveniles in specialized secure correctional facilities, including those dedicated to mental illness treatments, and juveniles supervised by specialized supervision probation officers, which include caseloads specifically focused on juveniles with mental illnesses.[56]

Evaluating Diversions from Incarceration

The recent era of juvenile justice reform efforts have largely focused on diversions from incarceration. A diversion is best understood as an intervention from formal processing or incarceration. The goal is to prevent any juvenile justice system involvement both now and in the future and to provide services for the juvenile offender.[57] In this context, a diversionary program for a mentally ill juvenile offender would include some sort of mental health services.

High recidivism rates and high costs have suggested the favorability of limiting traditional juvenile incarceration facilities for low-risk offenders. This sentiment also applies—perhaps with greater force—to mentally ill youths, as advocates generally believe that incarceration is unable to provide mental health treatment, either at all or with skill, and that conditions in some lockups are so grim that they may undermine the efficacy of the clinical interventions. Advocates for diversions from incarceration point to an array of investigations by the Department of Justice against juvenile lockups, many of which specifically note the lack of mental health care.[58] This treatment has been called "inadequate, substandard, or virtually nonexistent."[59]

In addition, the National Center for Mental Health and Juvenile Justice warned against "warehousing youth in juvenile justice facilities with no access to treatment,"* and stated that, "Given the needs of these youth and the documented inadequacies of their care while in the system, there is a growing sentiment that whenever possible and matters of public safety allow, youth with serious mental health disorders should be diverted into effective community-based treatment."[60]

Importantly, as the new juvenile justice agency in Texas is statutorily charged with increasing the proportion of youths in local custody, rather than committed to state lockups, the use of diversions is likely to increase in Texas. It is essential, then, that counties and local partners of the new department have solid information regarding the effectiveness and costs of these diversions, so that they may make informed decisions.

To make informed decisions, diversion programs must feature clearly substantiated long-term effectiveness to determine cost-effectiveness, especially as to mentally ill juvenile offenders, for whom ineffective programs can exponentially multiply long-term costs. There must be more transparency as to the programs outputs, including longitudinal data on effectiveness. Reformers must emphasize accountability for diversion programs, policymakers must ensure that effective programs are funded while ineffective ones are not, and practitioners must match the right program with the right youth.

*As discussed earlier, treatment in Texas' state facilities exists, but its effectiveness remains a question, due to the lack of data available to adequately evaluate their treatment tactics.

A Survey of Major Diversion Programs

As noted earlier, it is important that juvenile justice stakeholders have a grasp on the current information available covering diversion programs. However, the data on both the outcomes and costs of many diversionary programs has not kept up with the growth in the types or popularity of such programs, making it difficult for policymakers and stakeholders to make informed comparisons and decisions. Researchers have noted that within the last 20 years, the number of identified diversion programs has grown from 52 to 299.[61]

For example, in 2006, the National Center for Mental Health and Juvenile Justice noted the lack of a "comprehensive examination" of diversion programs, and how little was known about their funding and effectiveness, among other issues.[62] Their survey at that time of over 200 diversionary programs provided qualitative information on the various structural and demographic characteristics of these programs, but did not provide data comparing their effectiveness and costs.[63]

Nonetheless, even though incomplete, a survey of available data aids in identifying the information which is still needed, as well as being able to limitedly understand the benefits and drawbacks of diversions advocated for inclusion, even before the data is complete, in juvenile justice systems. This survey includes information on specific therapies used by diversions and general diversionary programs, some in the pilot project stage in Texas and some used in other jurisdictions. The lack of complete information on their costs and outcomes prevents any one program from being called a success, but optimism would certainly be appropriate, given the early reports.

Multi-Systemic Therapy

Multi-systemic therapy (MST) is an intensive family and community based treatment that addresses multiple determinants and underlying causes of serious illegal and delinquent behavior, including factors relating to the individual, family, and community, working with the juvenile and his or her family in the home.[64] MST is used to encourage family disciplinary capacity and diminish deviant behavior to overcome delinquency.[65]

This intensive treatment typically involves 60 hours of therapist contact over the course of 4 months.[66] Juveniles who have undergone MST show decreases of 25 to 70 percent in short-term and long-term recidivism, as measured by the number of arrests.[67] The empirical research demonstrating its efficacy has been sufficient to result in MST being designated by an evidence-based program by Blueprints for Violence Prevention at the University of Colorado at Boulder, the Office of the Surgeon General, and SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP).

In terms of costs, one estimate is of $5,900 per participant, for 60 hours of therapy over four months.[68] Another estimate, from the Washington State Institute for Public Policy, was a cost of $7,076, for use by juvenile courts.[69] In addition, the study determined that, based on a meta-analysis of national empirical research, for Washington, the benefits would total $23,856.[70] MST is used by some Texas juvenile probation departments and holds promise for broader implementation of Texas. Fidelity to the model, including the retention and recruitment of qualified staff, is a key factor in ensuring that the results reported in the research are obtained in practice.

Functional Family Therapy

Functional Family Therapy (FFT) is a three-phased (engagement and motivation, behavior change, and generalization) program that focuses on multiple factors that affect youth and their families, but mainly on discovering and building on each family's strengths.[71] The program includes behavioral change plans that are uniquely tailored to the special needs of each family member and ongoing multidimensional assessments to identify risk and protective factors to target in treatment.

Overall, FFT is a short-term intervention, ranging from 8 to 30 hours of direct services over a two to three month period, and concludes with sessions designed to ensure the families can maintain the changes and prevent relapses into delinquency.[72] One study has revealed that when FFT is delivered competently, it can deliver a reduction in recidivism of 38.1 percent,[73] while older trials suggested recidivism reductions between 20 and 60 percent.[74] Unfortunately, if delivery is not competent, the risk of recidivism is *raised* 16.7 percent.[75] This highlights the need for fidelity to the model and quality control. In many instances, FFT is provided by non-profit organizations that contract with juvenile justice agencies, which illustrates the need for competitive procurement and rigorous oversight processes which ensure that the entity selected to provide the service is qualified to do so and they are regularly monitored for both inputs, such as staff turnover, and outputs, such as the behavioral progress of youths on various assessments, avoidance of crises resulting in hospitalizations, and, ultimately, recidivism.

The reported cost in 2004 was $2,100.[76] Under a cost benefit analysis, if a competent therapist administered FFT, it yielded $10.69 in avoided crime costs for each dollar cost of the program.[77] But if not competent, it yielded $4.18 in additional taxpayer costs per dollar spent.[78] Sufficient empirical research has accumulated such that FFT has been designated an evidence-based program. The challenge for jurisdictions implementing it is to assure it is delivered in fidelity with the model and in the right dosage to the youths who can most benefit from it.

Community Corrections Diversion Program

As briefly discussed earlier, some Texas counties receive grants from the state as part of the Commitment Reduction Program or "Grant C," used to encourage diversions from TYC. This program was created in a rider to the budget passed by the Legislature in 2009. Initially funded with almost $50 million over the biennium, the program provides state funds to local probation departments that decrease their commitments to the state by diverting offenders from state-based incarceration. The program requires that the cost of these local initiatives not exceed $140 per day, per juvenile, or $51,100 per year.[79]

Through the use of this program, counties reduced commitments to state facilities by 32 percent, saving the $359 per juvenile, per year price tag for state lockups, and in the 2010 fiscal year, only 58 of the almost 4,000 youths served through this program were subsequently committed to TYC.[80]

However, in the first year of operation, only 10 counties receiving funding under this budget measure elected to include a mental health treatment component.[81] These counties may serve as sources of information for future expansion of mental health services through this grant, since TJPC requires counties to report performance measures on funded programs to them, and considers program effectiveness in deciding whether to continue funding in the next fiscal year. This funding stream creates an avenue for jurisdictions to develop innovative programs for diverting mentally ill youths, which could result in more applications for funding such programs in the future. Extending this budget measure to give counties that have already met their commitment target an opportunity to agree to an even lower target in future years could contribute to Texas being able to close additional TJJD lockups beyond the three shuttered in 2011.

Special Needs Diversionary Program

Texas has also adopted the Special Needs Diversionary Program (SNDP). This program combines mental health services with probation services, along with parental support and education. The most unique aspect of the program is that each juvenile is paired with a juvenile probation officer in addition to a licensed mental health practitioner.[82] The range of services provided includes case management services, skills training, therapy, medication, mentorships, and anger management, among others, all in a community-based setting, and in accordance with an individualized treatment plan.[83]

Each juvenile must meet certain criteria to be eligible for the program. First, the juvenile must be a member of the "priority population," which is defined as those juveniles with an Axis I diagnosis, along with one of the following statuses: a Global Assessment of Functioning* score under 50, a risk of removal from his or her home, or enrollment as a special education student.[84] Furthermore, there must be a family member or another adult willing to participate in the program with the juvenile offender.[85]

This program costs, on average, $58.93 per day,[86] and the average length of time enrolled in the program was 161 days, up from 130 at the beginning of the program, making the total program cost slightly higher than other diversionary programs discussed in this survey.[87] As for effectiveness, in the 2010 fiscal year, 1,400 juveniles were served by the program,[88] and of those discharged in the year 2010, 73 percent were considered successful, as defined as those not placed out of the home, discharged, or absconded.[89] Two percent of those enrolled in the program eventually were committed to TYC custody; however, half of those offenders had more than five previous referrals to the juvenile justice system.[90]

This 27 percent rate of unsuccessful juveniles may be better than recidivism rates generally—but this question cannot be definitively answered until more data is released. TJPC has only stated that mentally ill youths were rearrested for felonies or Class A misdemeanors at a rate of 38 percent in 2008. However, this is not enough information to adequately compare SNDP to standard probation—especially considering the significantly heightened costs involved.

*The Global Assessment of Functioning is a numeric scale that rates social, occupational, and psychological functioning on a scale of 0-100. A score of 50 represents "serious symptoms" or "serious impairment."

Given that many juveniles in the SNDP program had numerous previous referrals, the fact that a substantial number fail is not surprising, nor does it mean the program is not effective when compared to the unknowable counterfactual scenario in which it did not exist. In comparing various programs, it is always crucial to look at the types of offenders entering the program. While mentally ill offenders in general may have higher recidivism rates, they are a very diverse group in terms of both the extent and seriousness of their delinquency and the severity of their illness. Programs that serve low-level, first-time offenders with only a mild illness may be expected to have lower recidivism rates than those that serve a more challenging population.

Front-End Diversionary Initiative

Some Texas probation departments have begun a pilot diversion program for first-time offenders, the Front-End Diversionary Initiative (FEDI). This initiative is a pre-adjudicatory probation program which targets first-time juvenile offenders with a diagnosed mental illness and whose offenses make them eligible for deferred prosecution (usually, violent offenses remove eligibility for deferred prosecution).[91] The most unique aspect of FEDI is that each juvenile works with a Specialized Juvenile Probation Officer (SJPO) for each juvenile, and each SJPO works with no more than 15 juveniles at a time.[92]

The mental health care available through FEDI depends on the juvenile's resources. Those with Medicaid are linked to public mental health providers, those with private insurance are referred to private mental health providers, and offenders without either resource are referred to a partnering local university program that offers mental health services.

After six months of deferred prosecution, youth who comply with their case plans, and who are not rearrested, are released from supervision and adjudication, with an aftercare plan in place, including continued mental health care.[93] Youth who engage in delinquent behavior are removed from FEDI and referred to formal probation and adjudication.

Since its start in February 2009, of the 59 juveniles who have participated in the program, 95 percent (56) have not reoffended.[94] Furthermore, the cost per day per juvenile is only $4.52.[95] However, this cost does not include the cost of the mental health care provided by private insurance or Medicaid. The state share of Medicaid funding should be included in the accounting for FEDI to obtain an accurate picture of the cost to state taxpayers.

Furthermore, the FEDI program was initiated with the help of a private grant, and thus far, only one local probation department has allocated a probation officer to the SJPO position to continue the program. The degree to which the program can be replicated will depend on training SJPOs. While the limited results so far are encouraging, expansion efforts must either rely on continued private startup funding or take into account the cost of training SJPOs in determining the net savings that are achievable.

Collaborative Opportunities for Positive Experiences

In conjunction with a juvenile mental health court, Travis County, Texas established the Collaborative Opportunities for Positive Experiences program, or COPE, to divert juvenile offenders from formal adjudication or incarceration and instead provide treatment to juveniles, including mental health treatment.[96] Youth between the ages of 10 and 16 are eligible for the program, provided that they have been diagnosed with or suffer from a mental illness (other than conduct disorder or substance abuse), the juvenile has a pending, non-adjudicated referral for delinquent conduct, is appropriate for supervision through a deferred prosecution program, a family member who agrees to participate with the juvenile, and an assessment is performed within 90 days of the referral to COPE.[97]

COPE provides a specialized "Core Team" dedicated to the juveniles in the program, consisting of a mental health court judge, an assistant District Attorney, a public defender for juveniles, the COPE coordinator, two deferred prosecution probation officers, one probation case manager, and a psychologist, if needed.[98] Supervision under COPE lasts between six months and one year, and each juvenile has a stringent system of levels to complete to get the underlying charges dismissed. Each juvenile is subject to probation-style supervision as well as mental health treatment, including psychiatric evaluations and therapies, both individual and family-based, in the home and out of it.[99]

COPE was funded by a $246,662, two-year grant from the Bureau of Justice Assistance, and if the proposed 140 youths were served during that period, programmatic costs would be just over $1,700 per juvenile.[100]

In its first year, 41.8 percent of a total of 85 participants had been charged with a felony, and the rest were charged with a misdemeanor. The program featured a 69.1 percent "successful completion" rate and a 35 percent recidivism rate.[101] After 125 youths had been served, the successful completion rate was stated at 78 percent.[102]

Unfortunately, the released outcome data does not include a definition of success; furthermore, given the short-term existence of the program, long-term study will provide far greater information for evaluation and comparisons.

WrapAround Milwaukee

WrapAround Milwaukee is a collaborative program, which combines the mental health, juvenile justice, welfare, and educational systems, pooling funds from each system and ensuring a continuum of care.[103] Each juvenile is treated with a tailored treatment plan, which focuses on the family's strengths and the juvenile's neighborhood or community with an outcome-focused approach.[104]

Juveniles enrolling in the program must be between the ages of 10 and 21, diagnosed with a serious emotional disturbance, and involved with at least two of the following systems: mental health, child welfare, or juvenile justice.[105] In addition, youth offenders must have problems functioning well at home, in school, or in the community, as determined by a caseworker, and are at immediate risk for out-of-home placement in a residential treatment facility, juvenile corrections, or mental health hospital.[106]

When youths enter the WrapAround Milwaukee program, they undergo assessments, including a behavioral health diagnosis, and a determination of their "pressing concerns."[107] This determination will vary the services provided to each child, which include in-home therapy, outpatient or inpatient treatment, if necessary, medication, mentoring, foster care, job development, and many others.[108] Finally, a Mobile Urgent Treatment Team is also available to provide 24-hour crisis intervention services.[109]

The reported results of this program include a 60 percent drop in the use of residential treatment and an 80 percent drop in inpatient psychiatric hospitalization.[110] The drop in the utilization of residential programs resulted in savings of $8.3 million from 1996 to 2000.[111] However, youths exiting the program in 2009 were at home permanently at a rate of only 62.5 percent, although the program director notes that a total of 77 percent of youth completing the program in 2009 were able to be placed in a "permanent setting."[112] Recidivism rates at a one-year follow-up dropped by half for youths participating in WrapAround Milwaukee.[113]

The reported monthly costs for WrapAround Milwaukee were assessed at $3,786 per juvenile in 2009, with funds contributed by welfare, juvenile justice, and Medicaid agencies.[114] This requires a level of coordination among various government agencies that is challenging to achieve and likely requires high-level leadership from policymakers. Also, because one agency's actions may result in a cost for that agency but save another agency more than that cost, innovative approaches to allocating funding that go beyond the traditional silos between separate agencies would likely be important in implementing the WrapAround Milwaukee approach.

The Benefits and Limitations of Diversions

There are two common themes to effective diversions for mentally ill juvenile offenders. These themes instruct on selecting effective diversions as well as the appropriate targets for expenditures in the juvenile justice system.

First, successful outcomes for juveniles correlate highly with family involvement in their program and progress. This is merely an extension of what history dictates to be an important factor in raising juveniles to be law abiding citizens—strong parental control, discipline, and investment in their child. MST, FFT, SNDP, and COPE all involve an element of familial involvement. While this is unfortunately not possible for every juvenile, diversion programs should strongly focus on family involvement, incorporating a parent or guardian into the juvenile's progress whenever possible.

The second theme is of local, small programs. Each diversion program outlined above is focused on local factors, the issues and needs of juveniles at the county or local level, rather than broad one-size-fits-all state programming. This is a logical theme for effective juvenile justice, as counties tend to be able to better place youths and tailor their delinquency response based on local factors and issues. With local control, counties can ensure that the youth is in the program that is most cost-effective and that limited space in residential and in-home programs is most efficiently allocated, and that care providers for mental illnesses are geographically accessible. In contrast, most incarcerated mentally ill youths are currently sent to a facility in Corsicana, Texas, which is not geographically located near most mental health professionals.

Overall, diversions present a more cost-effective approach. While Texans paid $359 per day, per juvenile offender, for incarceration at TYC in 2010, diversions often cost less, as in-home programs in Texas cost on average between $48 and $73 a day.[115] Of course, this benefit must be viewed in light of public safety outcomes over a substantial period of time, which could theoretically be better or worse than incarceration. Furthermore, estimates of savings should take into account how many youths diverted nonetheless sub-

sequently become incarcerated, meaning both costs have been incurred. Such information must be carefully evaluated with an understanding of the total costs involved for a diversionary program.

Further, in addition to potentially lower costs, diversionary alternatives based on solid research and implemented with fidelity to program design have achieved relatively low recidivism rates.[116] If further research confirms this initial perception, each tax dollar spent on mental illness treatment through a diversion would go further and be used to better address a greater number of juvenile offenders. However, more information is required to comprehensively evaluate the effectiveness of specific diversion program for mentally ill youths with various offense, risk, and medical profiles.

However, diversion programs generally are limited in several respects. First, any time a juvenile offender is diverted from incarceration, public safety concerns will follow, though incarceration merely postpones those concerns given that the average length of placement in a country-run post-adjudication facility is 87 days, and 14 months in a state lockup. Any diversion program must address public safety concerns through the use of risk assessment to ensure offenders are matched with the right level of supervision and treatment and through controlled studies demonstrating long-term recidivism reduction.

Second, another limitation is maintaining fidelity to an effective model program as it is replicated. This often depends on local factors such as sound management practices, recruitment and retention of qualified staff, and the use of outcome-oriented performance measures to identify adjustments that may be needed in the program.

Policy Directions

While there is clearly a need for transparency and better access to information, the information available suggests policy directions for Texas that will provide a more efficient and effective system both now and in the future, taking into account both the benefits and limitations of initiatives to divert mentally ill youth offenders.

Minimum Standards

While more data is required to fully evaluate the diversions from incarceration noted in this paper, the preliminary results suggest two minimum standards that policymakers should be careful to require out of any diversion program selected for use at the county or state level.

First, the diversion should cost less than half of the daily cost of a secure facility. Many diversions cost far less than this, but this ceiling on the appropriate cost for a diversion can help guide policymakers towards the most cost-effective diversions, and eliminate needless and costly options.

Second, the diversion should provide at least double-digit percentage reductions in recidivism rates. Again, while some diversions offer better outcomes, this is the minimum that policymakers should require out of a diversionary program submitted for its consideration. Further, this ensures that the diversion would be more effective than current outcomes for mentally ill offenders exiting state lockup facilities, which are stated to reduce recidivism by 9.4 percent.

By requiring that these two benchmarks are met by any diversion program, policymakers can ensure that the program is, at the very least, less expensive and more effective than state lockups. Further benchmarks can and should be established once more comprehensive data is released on diversions and current juvenile justice practices.

Greater Transparency

This report has consistently noted the lack of information, as well as deficiencies in the information that has been published, which in many instances prevents meaningful comparisons between current policies and practices and various alternatives. Among the areas where greater information transparency is needed to guide future policy decisions are:

- Longitudinal data on rates of mentally ill juveniles at the county level.
- Data on the juveniles at the county level, identified as having a mental illness, who did not receive treatment.
- General data on current institutional mental health care in Texas.
- Data on the effectiveness of the MAYSI-2, in direct comparison to other screening instruments.
- A study as to whether the incidental effects of screening highlighted in Pennsylvania are present in Texas agencies as well.
- Follow-up information on juveniles screened in by the MAYSI-2, as compared to those identified as having a mental illness otherwise.

- Recidivism rates for youths in state facilities, with careful delineations between mentally ill youths who did and did not receive treatments, and the underlying data supporting those comparisons.
- Additional information on the number of youths served by state mental health programs in high-security lockups and the costs involved.
- Segregated record keeping on the state's specialized correctional treatment programs.
- Comparative information on institutional mental health expenditures across state agencies.
- Better information on the expenditures associated with SNDP and which agency funds what portions of the program, and to what degree.
- More recidivism data from counties on mentally ill offenders, including three-year reincarceration rates, as long as comparable data on non-mentally ill offenders.
- Comprehensive Texas and national data on diversion programs generally, as to both costs and effectiveness.
- A comparison of the total costs of diversion programs and the same treatments within state facilities.
- The long-term recidivism rates for offenders sent to diversions.
- Data on the coercive impact of judicial leverage into mental health treatments and whether that weighs on effectiveness.
- Texas-specific data on MST and FFT demonstrating the extent to which jurisdictions are achieving fidelity with the proven national model.
- Whether additional community-based initiatives can be developed through the Commitment Reduction Program to more broadly supervise and treat mentally ill juvenile probationers.
- A study on recidivism rates following the use of SNDP as compared to recidivism rates for TJPC-involved youths, generally.
- Information on the youths permitted to become involved with the SNDP program, including their prior criminal histories and whether those criminal histories affect the program's effectiveness.
- More accurate funding information for FEDI, taking into account mental health care costs not currently included in the total, as well as start-up costs to expand the program.
- Program costs and efficiency measures for the COPE program in Travis County, Texas.
- Data on the extent of reentry programming provided to mentally ill youths leaving juvenile detention, county-run post-adjudication facilities, non-secure residential placement facilities, and state facilities, and the impact of such programming on outcomes.

Increased State Spending Isn't Necessarily the Answer

The possible linkages between the civil mental health system and the corrections system is an area of concern for many policymakers and advocates. Undoubtedly, there are youths with mental health issues who both enter the juvenile justice system following involvement in the civil mental health system and those who did not access mental health treatment prior to entering the juvenile justice system. Yet, without an individualized review of each youth's records, it is difficult to determine the extent to which issues of access and effectiveness in the civil mental health system affect the juvenile justice system.

Nonetheless, many reports on juvenile offenders in Texas argue that Texas' low spending on public mental health systems has affected the rate of juvenile offenders with a mental illness. A common assertion is that mentally ill juvenile offenders' prevalence in the juvenile justice system is due, at least in part, to low levels of spending on community mental health services. This creates unmet need for mental health treatment in these juveniles, which culminates in justice-system involvement.

For instance, the Texas Mental Health Association wrote that, "Deinstitutionalization, inadequate community mental health programs, and limits imposed by private insurance plans have all combined to increase the likelihood that persons with mental illness will wind up in the criminal justice system."[117] Similarly, the Texas Association of Nonprofit Organizations advocated for increased spending for public mental health systems, suggesting that lower funding for these organizations resulted in increased spending—in part by the juvenile justice system—later.[118] And nationwide, this belief is echoed often, as portrayed by the *New*

York Times' suggestion of a correlation between spending on community mental health programs and the number of juvenile offenders with a mental illness.[119]

However, the evidence does not necessarily support these claims. Looking at Texas, in 2009 average state mental health authority spending per youth was $18.85 per capita, compared to a national median of $79.54, with four states spending less than Texas.* And an analysis of Medicaid claims in 23 states indicated a prevalence of youth mental illness in Texas of only 6 percent compared with the average of 9 percent.

Neither does the lower level of spending in Texas mean that youths are not getting assistance. As of August 2011, there were 281 children waiting for services at local mental health authorities with whom DSHS contracts for community mental health services.[120] This represents a decrease from August 2010 when it was 315.[121] Of the 281, 40 of them were receiving some level of service but were "underserved," meaning they were not receiving the level of service they needed/were eligible for.[122] Youths on the waiting list typically will receive mental health treatment eventually. Additionally, youths whose condition is so serious and urgent as to indicate they could hurt themselves or others if not promptly treated are prioritized by MHMR and receive immediate crisis services.

In addition to Texas, an analysis of the states which increased spending on public mental health services—sometimes at very high levels—for children in the past decade reveals that this does not necessarily produce a negative correlation with later justice system involvement by mentally ill juvenile offenders. Although the reason for this is not clear, where resources are plentiful, there may be a tendency to use complex combinations of medications and hospitalization to excess, which can be less effective than a more restrained treatment regimen in less severe cases. Indeed, a 2011 study of 200 youths admitted to a Wisconsin adolescent treatment unit found many youths were administered and prescribed upon departure several drugs at once, and that "some of this psychiatric polypharmacy may be of little benefit for a given patient" and "at least some patients may experience serious medication-induced behavioral adverse effect."[123]

For example, in 2001, the state of Alaska was spending $37.81, per capita, on children's mental health through State Mental Health Authority (SMHA)-controlled dollars.[124] This amount increased to $359.24, per capita, in 2009, an increase of over 950 percent.[125] This increase over eight years of youth-based mental health spending did not have a noticeable effect on the share of juvenile offenders with a mental illness. In 2001, Alaska reported that 42.5 percent of the youth in the juvenile justice system received an Axis I Diagnosis. In 2010, Alaska the number was 43 percent[126]—virtually the same as Alaska's proportion in 2001 and practically the same proportion as Texas in 2009, which spent only $18.85 on children's mental health through SMHA-controlled dollars in 2009.[127]

In North Carolina, SMHA-controlled spending on children's mental health grew from $50.58 per capita in 2001 to $347.60 in 2009.[128] Again, just like in Alaska, a high increase in spending on mental health care did not preclude mentally ill juveniles from involvement with the justice system. The North Carolina Department of Juvenile Justice reported that 75 percent of its youth had mental health needs in both 2004 and 2007.[129]

In comparing states on overall youth mental illness policy, we find Texas both spends less on youth mental illness, at least at the state agency level, and has a lower prevalence rate than most states. While there are many possible explanations for this, and the lack of a correlation between increased spending and improved outcomes for mentally ill juvenile offenders does not prove increased spending is without benefit, it does indicate a need to closely scrutinize requests for additional state mental health funding and examine whether existing funds across the nation could be more efficiently spent.

Information Sharing

One way for Texas agencies to begin improving available information as well as to strengthen their current programs is through enhanced information sharing between agencies. The information obtained through the screening administered by TJJD should be effectively shared amongst state agencies. In 2011, the Texas Legislature passed Senate Bill 1106, which requires disclosure of information from educational records, health records, and records regarding the prior use of governmental services upon request by another

* These spending figures refer only to spending by the state mental health agency and therefore do not include Medicaid, the Children's Health Insurance Program (CHIP), school mental health counselors, private insurance, or mental health care through a charitable source.

agency.[130] The legislation also authorized the establishment of internal protocols to facilitate the information sharing, and ensures that information privacy is still respected even while sharing this information. Texas juvenile justice agencies must take advantage of this authority granted by the legislature and make the needed requests and establish memoranda of understanding, as the adult justice agencies already do,[131] with local probation departments, school districts, and community mental health services laying out the various request processes and responses to the requests. Point personnel and timelines must be identified within each entity to streamline the effectiveness of this process. Furthermore, as information resources advance, long term, coordinating databases can provide ease of use in this practice. Such information sharing is a vital step towards achieving comprehensive mental illness treatment and response. Prior history, prior treatments and medication courses, and prior testing information can all be disseminated using this legislation. This has the potential to reduce duplicative efforts by governmental agencies for each youth, to prevent conflicting treatment plans, and to reduce the chances that mentally ill youths may not be properly identified.

Ongoing Treatment

No matter where mental health treatment takes place, continuity of care is essential in ensuring that mental health issues are mitigated to the extent possible. After being released from supervision, a juvenile offender with a mental illness with the opportunity to continue his or her treatment will be better off, long term. Chronic conditions like mental illnesses can typically be managed over time—but only with adherence to a treatment plan. While it is very difficult to ensure that a juvenile continues taking his or her medication or continues going to therapy, policymakers have some options. For example, TJJD recently began a policy of communicating with parents of committed youth by sending letters home explaining the medication program their child has been prescribed, the effects, and the child's future prescriptive needs.[132] This program is a low-cost way to get parents involved in their child's treatment program and to increase the odds that treatment will continue post-incarceration. Similar letters from probation and community-based supervisory programs may also increase the odds of a continuation of treatment as well as family involvement.

Conclusion

It is clear that there is not a single program that is the one answer for all mentally youths in the Texas juvenile justice system, who vary widely in the risk and needs they present. Indeed, there is a significant need for further research to identify those programs that are most cost-effective for various subgroups. In addition to the recognition that the problem in most cases is both a medical and correctional one, accurate assessments are critical to ensuring limited treatment resources are focused on the right youths and avoiding youths being wrongly diagnosed. Many of the most promising diversion programs share a common thread of combining treatment with supervision strategies that hold the youth and their family accountable for compliance and address the criminogenic risk factors, some of which are manifestations of the illness and some of which may be associated with other factors, such as the environment in which the youth grew up.[133]

Some long-standing diversion programs such as MST and FFT are grounded in sufficient research to demonstrate effectiveness when implemented with fidelity to the original model in the appropriate cases, while other newer diversion programs have yielded promising results in a particular jurisdiction but would benefit from a controlled, randomized empirical research to confirm their effectiveness.

With a new juvenile justice agency, Texas has an exciting opportunity to take a comprehensive approach in evaluating all aspects of the system that mentally ill youths come in contact with from entry to reentry and to enhance best practices such as information sharing that can lead to better public safety outcomes and lower costs. The new agency also has an opportunity to collect more probative data on the effectiveness of programs that serve mentally ill youths and their longitudinal progression through the system that is currently unavailable, giving policymakers a better sense of where limited funds are best deployed. Armed with such additional information, policymakers and practitioners can take the next steps to advance the interests of public safety, fiscal responsibility, and the rehabilitation of troubled youths. ✯

[1] Thomas Grisso, "Progress and Perils in the Juvenile Justice and Mental Health Movement," *The Journal of the American Academy of Psychiatry and the Law* 35:158-67 (2007) 159.

[2] *See*, e.g., Janet Williams et al., "Not Just Child's Play: The Role of Behavioral Health Screening and Assessment in the Connecticut Juvenile Justice System," The Connecticut Center for Effective Practice of the Child Health and Development Institute of Connecticut, Inc. (2005) 3; Thomas Grisso and Valerie Williams, "What do We Know About the Mental Health Needs of Pennsylvania's Youth in Juvenile Detention? Findings and Recommendations from the Mental Health Assessment of Youth in Detention Project," Juvenile Detention Centers Association of Pennsylvania (July 2006) 1; Kathleen R. Skowrya and Joseph J. Cocozza, "Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System," National Center for Mental Health and Juvenile Justice Policy Research Associates, Inc. (2007) vii; "The Officer Will See You Now: Reversing the Trend Toward the Juvenile Justice System As Default Mental Health Provider for Texas Kids," Texans Care for Children (May 2010) 2.

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[12] Thomas Grisso, "Progress and Perils in the Juvenile Justice and Mental Health Movement," *The Journal of the American Academy of Psychiatry and the Law* 35:158-67 (2007) 162.

[13] John Posey, Planner, Texas Juvenile Justice Department, email, Jan. 3, 2012.

[14] Jennifer Schwank et al., "Mental Health and Juvenile Justice in Texas," Texas Juvenile Probation Commission (Feb. 2003) 42.

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[29] "2007 Review of Agency Treatment Effectiveness," Texas Youth Commission (2008).

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[31] "Texas Youth Commission Reform Plan," Texas Youth Commission (July 2008) 12.

[32] "2010 Annual Review of Agency Treatment Effectiveness," Texas Youth Commission (31 Dec. 2010) 14.

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