Where We Are and Where We’re Going in Policy and Practice in NYC
February 16, 2010

Oversight: Merging the Department of Juvenile Justice and the Administration for Children’s Services.

On February 16, 2010 at 11:00 a.m., the Committees on Juvenile Justice and General Welfare, chaired by Council Members Sara Gonzalez and Annabel Palma respectively, will conduct an oversight hearing to examine the merger the Department of Juvenile Justice (“DJJ”) and the Administration for Children’s Services (“ACS”). Those
expected to testify include representatives from ACS, the Legal Aid Society, the Children’s Defense Fund, community-based organizations, and other interested parties.

BACKGROUND

On January 20, 2010, during his State of the City speech, Mayor Bloomberg announced an overhaul of the City’s juvenile justice system by stating that DJJ would be integrated into ACS. Citing recent findings about the success of alternative to placement programs in reducing juvenile recidivism rates when compared to “dangerously dysfunctional” State residential facilities, the Mayor stated that, through integration, the City would be able to provide better services for those in detention and to provide stronger supervision for those who can be safely maintained in the community.¹ According to ACS, with the merger, child welfare programs will be used to create long-term planning for youth and their families upon entering into the juvenile justice system.² It would also merge two agencies that serve overlapping populations. Below is a brief description of the juvenile justice system, each agency, and how their missions overlap.

New York State Juvenile Justice System

The juvenile justice system has two overarching goals: the protection of public safety and to care for and rehabilitate youth while they are detained or placed in a youth detention or correctional facility. When youth become involved in the juvenile justice system, they interact with a number of city and state agencies that work together to make up the juvenile justice system. These agencies include the New York Police Department, the City’s Corporation Counsel, the Department of Probation (“DOP”), Family Court, DJJ, ACS, and the New York State Office of Family and Children Services (“OCFS”).

¹ Mayor Michael Bloomberg’s State of the City Address, January 20, 2010.
The Department of Juvenile Justice ("DJJ")

DJJ is charged with coordinating the detention of the City's justice involved youth. Juveniles, ages 7 through 15, who are detained in DJJ facilities include alleged juvenile delinquents and offenders whose cases are pending before the courts, and those whose cases have been adjudicated and are awaiting transfer to OCFS facilities. In FY 2009, 5,833 juveniles were admitted into DJJ's facilities with an average length of stay of 26 days. While juveniles are in detention, DJJ provides a number of services. Services include, but are not limited to, case management, medical, dental and mental health, education, recreation, ombudspersons, discharge planning and chaplain services.

DJJ manages three full service secure detention facilities: Bridges, Horizon and Crossroads. Secure detention facilities are characterized by locks on the doors and other restrictive hardware designed to limit the movement of the residents and to protect public safety. Secure detention facilities maintain an 8 to 1 juvenile to staff ratio pursuant to State rules.

DJJ oversees 16 non-secure detention ("NSD") facilities located throughout the City, two of which are run directly by DJJ. The NSD program offers an alternative to secure detention for some of the young people remanded to DJJ's custody. NSD provides less-restricted but structured residential care for alleged juvenile delinquents awaiting disposition of their cases in Family Court. NSD facilities are characterized by the absence of physically restrictive hardware, construction, and procedures. NSD offers

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6 9 NYCRR 180.9 (c) (15).
juveniles a supportive environment and close supervision during their time in detention. Pursuant to State rules, NSD facilities hold no more than 12 juveniles and must have at least two staff members on site.

Detention facilities offer an opportunity to deliver and coordinate medical and mental health care to high-risk youth, especially when they have not had access to such care prior to admission. DJJ is required to provide health and mental health services for all remanded youth. New York State requires that all detention facilities have a medical program to provide “adequate and appropriate health services” to the youth who need them. The requirement includes basic primary health, dental, gynecological and mental health services. In addition to addressing a youth’s basic health needs while detained, DJJ is required to ensure the continuity of medical care for youth that are under medical or psychiatric treatment prior to detention.

DJJ also provides discharge planning services to juveniles in detention. The Discharge Planning Unit (“the Unit”) works with youth and their families while they are in detention to help them identify service needs and connects them with the appropriate aftercare service providers. Among the myriad of service needs juveniles in detention require are: medical and mental health issues, literacy, truancy, HIV-education, alcohol and substance abuse treatment, violence reduction, conflict resolution, computer skills, life skills, anger management, and leadership development. The Unit works to identify individual issues and concerns of the youth and begins to address them during detention.

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8 Id.
9 NYCRR 180.10 (b).
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11 Id.
12 41 RCNY §3-01.
14 Id.
The Unit then creates a plan to address those needs after a juvenile’s release and works with community based organizations to provide these services.\textsuperscript{15}

\textbf{Administration for Children Services ("ACS")}

ACS’s mission is to ensure the safety, permanency and well-being of New York City’s children.\textsuperscript{16} ACS offers a vast range of services and referrals to programs that support children and strengthen their families, which include both child welfare and child care services. In the child welfare context, ACS is responsible for, among other things, investigating reports of child abuse and neglect, and for filing and prosecuting abuse and neglect cases in Family Court when it is appropriate. By contracting with private foster care agencies, ACS also provides foster care services to children and families who need them. ACS and its contractors make referrals for services such as counseling, substance abuse programs, and parenting classes, with the goal of achieving permanency for children as quickly as possible.\textsuperscript{17} In addition, ACS partners with community based organizations to provide preventive services in communities, which are designed to keep children safe at home and avoid their placement into foster care.\textsuperscript{18}

The agency is also responsible for providing subsidized child care to eligible families, which it does for approximately 120,000 children in the City.\textsuperscript{19} ACS does not directly operate child care services, but instead contracts with private, non-profit organizations that operate child care programs. In addition, ACS issues vouchers to

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eligible parents who may then utilize them as payment in any type of legal child care facility in the City.\textsuperscript{20} ACS also sponsors approximately 250 Head Start child care centers, which serve children ages 3 to 5.\textsuperscript{21}

ACS works with youth and adolescents in a number of capacities. Many of the youth involved in DJJ may already be involved with ACS, for example if they have an open child abuse or neglect case or are in foster care. Of special interest to this hearing, however, are the programs that ACS currently administers that are aimed at the population most similarly served by DJJ, namely, the Juvenile Justice Initiative ("JJI") and the Person in Need of Supervision ("PINS") system. Below is a brief description of both.

\textit{The Juvenile Justice Initiative ("JJI")}

Initiated in February 2007, JJI provides intensive, "evidence-based" services\textsuperscript{22} for youth involved in the juvenile justice system.\textsuperscript{23} The program's goals are: "to reduce the number of delinquent youth in [state] residential facilities; shorten lengths of stay for those youth that are placed in [state] residential care; reduce recidivism; and improve individual and family functioning."\textsuperscript{24} JJI consists of two programs, one that provides services to youth who would otherwise serve time in state institutional settings (the Alternative-to-Placement program), and another that provides services to youth who are

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\textsuperscript{24} Id.
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JJI utilizes three therapeutic models that research has shown to be very effective in improving long term outcomes for youth -- Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Treatment Foster Care (MTSC). FFT was designed to assist youth and families who already had received some supportive services and did not believe they could change. In particular, this model has worked well for families with “significant family violence.” Under the FFT model as utilized in the JJI program, a therapist regularly meets with the entire family at home over a period of three to five months. The therapist works to engage not just the youth but all family members, to create long term behavior plans for each family member, and to help the family utilize community resources.

MST therapists in the JJI program also provide therapy to the entire family in the home, visit several times a week, are accessible by phone 24 hours a day, and have a maximum caseload of six families. Therapists engage the youth’s “entire social network” to help make positive changes, and use various types of therapies to address

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25 Id.
28 Id.
29 Id.
issues such as substance abuse, family dysfunction, negative peer influences, and poor school attachment.\textsuperscript{30}

The JJI program also utilizes the MTFC model, where a specially trained foster family cares for the youth for six to nine months, and, with a family therapist and a therapeutic treatment team, helps to implement "an individualized program that sets clear rules, expectations, and limits to manage behavior."\textsuperscript{31} Concurrently, the youth's family receives intensive therapy and skills training to prepare them for the youth's return home, specifically by helping them make changes in parenting style, and teaching them how to provide consistent supervision and discipline.\textsuperscript{32} When the youth returns home, the family continues to receive MST "until the family and youth are able to show sufficient progress."\textsuperscript{33}

JJI also has a pilot program called "Blue Sky," which is operated by The New York Foundling, an organization that provides community based services to children and families. Blue Sky is the first program of its kind, and it utilizes all three therapeutic models. Accordingly, the youth may transition in and out of different models, depending on the youth and family's needs and responses to the different types of treatment.\textsuperscript{34}

On January 13, 2010, ACS announced that it had received a $1.1 million grant from the Robin Hood Foundation to expand JJI to serve justice involved youth with serious mental illnesses, a group that had not previously qualified for participation.\textsuperscript{35}

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New York Foundling will provide community based treatment to youth and their families with intensive home and evidence based services.\textsuperscript{36} This portion of JJI will use the Psychiatric Adaptation of Multisystemic Therapy, where families will work closely with therapists and have access to a crisis worker 24 hours a day.\textsuperscript{37}

\textit{Person in Need of Supervision ("PINS") System}

The New York State Family Court Act defines a PINS as a "person less than eighteen years of age who does not attend school... or is incorrigible, ungovernable or habitually disobedient and beyond the lawful control of a parent..."\textsuperscript{38} Parents who have a child that may fit the abovementioned definition and feel overwhelmed, frustrated or emotionally drained in raising their adolescents may file a PINS petition with the Family Court.\textsuperscript{39} The petition authorizes the justice system to help parents supervise their adolescents or place them in residential or foster care. If a parent files such a petition, they are required by state law to go through a diversion program to divert the youth from being the subject of a PINS petition.\textsuperscript{40} In New York City, the diversion program is known as the Family Assessment Program ("FAP"), which is jointly administered by ACS and DOP.\textsuperscript{41}

FAP provides support to families to help them resolve problems such as truancy, running away or unruly behavior – examples of complaints driving parents to file PINS petitions. Families in FAP meet with a Family Assessment Specialist, an experienced

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ACS social worker especially trained in family problem solving. The social workers work with parents and adolescents to identify service needs and to provide referrals to the most appropriate services to help them work through their challenges. Examples of the types of referrals provided to participants include: crisis intervention, mediation, family counseling, substance abuse services, domestic violence programs and anger management programs. Families are required to go through the entire FAP process before proceeding with the PINS process. If the services fail to address the family’s issues and the PINS system must be used, the Family Assessment Specialist would facilitate a conference between the DOP and the family to discuss the outstanding issues, the court process and other possible options.

Once the family files a PINS petition in Family Court, a Family Court judge presides over a fact finding trial to determine whether or not the child in question is a “person in need of supervision”, or PINS. If the judge finds that the child needs supervision, the child may be sent home under the supervision of the DOP. The judge may also place the child into foster care, a group home or a social service facility for up to 18 months. The foster home or social services facility may be run by ACS directly or may be contracted out by ACS.

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\(^{45}\) While under supervision of the DOP, the adolescent is assigned to a Probation Officer (“P.O.”) who sets up a reporting schedule and a treatment plan based on the needs of the youth and his or her family. POs may make home visits, refer the adolescent to a community-based treatment provider and they also monitor his or her adjustment at home, at school and in the community to ensure compliance with the conditions of probation. See: http://www.nyc.gov/html/prob/html/programs/programs_services.shtml.
Issues and Concerns

The Mayor’s statements supporting the integration of DJJ into ACS suggests that New York City is changing its overall policy concerning juvenile detention, from a punitive model that provided some supportive services, to a more therapeutic model with a greater focus on providing services to youth and their families in their community. As stated above, a number of agencies in addition to DJJ and ACS play a role in determining whether or not a child gets detained, including DOP and Corporation Counsel. Aside from the merger of DJJ and ACS, a change in how these other City agencies and offices make detention recommendations must also be made in order to achieve comprehensive juvenile detention reform. The Committees seek to clarify just how much of a policy shift this merger represents and whether such a policy change will be reflected across other agencies as well.

Mayor Bloomberg’s decision to incorporate DJJ into ACS is, in theory, a rational one, as both agencies deal with overlapping populations that have similar needs as outlined above. A major concern for both Committees, however, is that ACS, already charged with a broad mandate, is being given the responsibility for administering yet another large and complicated system – the City’s entire juvenile detention system. In the past several years, the General Welfare Committee has held several hearings questioning whether ACS is adequately serving the City’s children. For example, in recent years the General Welfare Committee has raised concerns about several issues: that ACS is not adequately preparing youth for adulthood as they age out of foster care;46

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the effect of significant budget cuts on the agency’s ability to protect children;\textsuperscript{47} and ACS’ ability to create a sustainable model of child care in the City.\textsuperscript{48} The Committees are concerned that giving ACS even more responsibility than it already has may negatively affect the quality of both its and DJJ’s existing programs.

The Committees also seek to learn much more about the integration process itself. Specifically, the Committees would like to learn how the integration will take place and the time that the Administration anticipates it will take to achieve full integration. Though it is understandable that such information may not yet be available, the Committees remain interested in monitoring the integration process and plan to hold future follow-up hearings to ensure that the changes being made are most beneficial to the youth that both agencies are dedicated to serve.

\textsuperscript{47} New York City Council Preliminary Budget Hearing, Administration for Children’s Services, March 23, 2009; see also New York City Council Fiscal Year 2010 Executive Budget Hearing, Administration for Children’s Services, May 26, 2009.

\textsuperscript{48} Hearing of Committee on General Welfare entitled “Oversight: ACS’ Efforts to Preserve Child Care Centers in New York City,” April 10, 2008; see also Hearing of the Committee on General Welfare entitled “Oversight: Project Full Enrollment: Are We Creating a Sustainable Model for Child Care in New York City?,” June 17, 2008.
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Issues and Concerns

The Mayor's statements supporting the integration of DJJ into ACS suggests that New York City is changing its overall policy concerning juvenile detention, from a punitive model that provided some supportive services, to a more therapeutic model with a greater focus on providing services to youth and their families in their community. As stated above, a number of agencies in addition to DJJ and ACS play a role in determining whether or not a child gets detained, including DOP and Corporation Counsel. Aside from the merger of DJJ and ACS, a change in how these other City agencies and offices make detention recommendations must also be made in order to achieve comprehensive juvenile detention reform. The Committees seek to clarify just how much of a policy shift this merger represents and whether such a policy change will be reflected across other agencies as well.

Mayor Bloomberg's decision to incorporate DJJ into ACS is, in theory, a rational one, as both agencies deal with overlapping populations that have similar needs as outlined above. A major concern for both Committees, however, is that ACS, already charged with a broad mandate, is being given the responsibility for administering yet another large and complicated system – the City's entire juvenile detention system. In the past several years, the General Welfare Committee has held several hearings questioning whether ACS is adequately serving the City's children. For example, in recent years the General Welfare Committee has raised concerns about several issues: that ACS is not adequately preparing youth for adulthood as they age out of foster care;\footnote{Hearing of the Committee on General Welfare, “Oversight: The Administration for Children's Services Efforts to Prepare Youth Aging Out of Foster Care for Independent Living,” June 21, 2007.}
the effect of significant budget cuts on the agency’s ability to protect children;\textsuperscript{47} and ACS’ ability to create a sustainable model of child care in the City.\textsuperscript{48} The Committees are concerned that giving ACS even more responsibility than it already has may negatively affect the quality of both its and DJJ’s existing programs.

The Committees also seek to learn much more about the integration process itself. Specifically, the Committees would like to learn how the integration will take place and the time that the Administration anticipates it will take to achieve full integration. Though it is understandable that such information may not yet be available, the Committees remain interested in monitoring the integration process and plan to hold future follow-up hearings to ensure that the changes being made are most beneficial to the youth that both agencies are dedicated to serve.

\textsuperscript{47} New York City Council Preliminary Budget Hearing, Administration for Children’s Services, March 23, 2009; see also New York City Council Fiscal Year 2010 Executive Budget Hearing, Administration for Children’s Services, May 26, 2009.

\textsuperscript{48} Hearing of Committee on General Welfare entitled “Oversight: ACS’ Efforts to Preserve Child Care Centers in New York City,” April 10, 2008; see also Hearing of the Committee on General Welfare entitled “Oversight: Project Full Enrollment: Are We Creating a Sustainable Model for Child Care in New York City?,” June 17, 2008.
New York State/
New York City
Mental Health-
Criminal Justice Panel

Report and
Recommendations

to
Governor David A. Paterson
and
Mayor Michael R. Bloomberg

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June 2008
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D. Finding: insufficient training, supports and tools to identify and engage individuals with mental illnesses in the criminal and juvenile justice systems

Recommendations
1. Pilot a New York City alternative-to-detention program
2. Create a dedicated mental health unit within the New York City Department of Probation
3. Include validated mental health screening in pre-sentence investigations
4. Pilot mental health screening in criminal court for individuals sentenced to community-based sanctions
5. Expand new mental health courts and alternatives-to-incarceration
6. Improve training for 911 call takers and dispatchers
7. Sponsor a statewide mental health-law enforcement summit
8. Continue ongoing review of best practices for dealing with “emotionally disturbed person” incidents in New York City Police Department’s training curriculum
9. Enhance clinical interventions for youth with serious emotional disturbance in Department of Juvenile Justice’s or Office of Children and Family Services’ custody

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I. Executive summary

In the wake of several recent, highly publicized violent incidents involving individuals with mental illnesses, officials in New York State (NYS) and New York City (NYC) convened a panel to examine these cases, consider opinions of experts and recommend actions to improve services and promote the safety of all New Yorkers.

The NYS/NYC Mental Health and Criminal Justice Panel (Panel) was convened by NYS Deputy Secretary for Health and Human Services Dennis Whalen and NYC Deputy Mayor for Health and Human Services Linda Gibbs. The Panel was co-chaired by NYS Office of Mental Health Commissioner Michael Hogan, NYS Division of Criminal Justice Services Commissioner Denise O’Donnell, NYC Deputy Mayor Linda Gibbs and NYC Criminal Justice Coordinator John Feinblatt. Members of the Panel included top State and City officials in mental health, substance use, criminal justice and adolescent services.¹

The Panel’s work was informed by a review of several cases in NYC involving individuals with serious mental illnesses who engaged in violent behavior and encountered law enforcement and the criminal justice system, as well as a broader assessment of how New York’s mental health and justice systems respond to adults and adolescents with serious mental illness. The Panel also consulted with national experts in mental health and violence.

The Panel focused on opportunities to improve services for the subset of individuals with serious mental illnesses who are at risk of poor treatment outcomes, violence, and involvement with the justice system. This targeted focus is supported by an extensive body of research indicating that the vast majority of those with mental illnesses are not violent, and that mental illness is not a major driver of violent crime—in fact, studies show that individuals with mental illnesses are far more likely to be victims of violence than the general population.² Research does suggest, however, that the risk of violence is significantly increased among individuals with mental illnesses who do not receive adequate mental health care,³ and considerably more so among those individuals with co-occurring mental health and substance use disorders.⁴

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Notes

1. See Appendix A for Panel’s membership list.
Panel findings

Panel members identified many ways in which both the mental health and criminal justice systems could improve their ability to help adults and adolescents with serious mental illnesses. The challenges fall into four broad categories: 1) poor coordination, fragmented oversight and lack of accountability in the mental health treatment system; 2) inconsistencies in the quality of care within the mental health treatment system; 3) limited capacity to share information within and between the mental health and criminal and juvenile justice systems; and 4) insufficient training, supports and tools to identify and engage justice-involved individuals with mental illnesses. Following are specific recommendations within each of these categories. While designed to respond specifically to incidents in NYC and its system of care, the Panel believes that this report’s conclusions have broader statewide application.

**1. Poor coordination, fragmented oversight and lack of accountability in the mental health treatment system**

**Recommendations:**

- **Establish Care Monitoring Teams for High-Need Adults** – The NYS Office of Mental Health (OMH) and the NYC Department of Health and Mental Hygiene (DOHMH) should jointly establish and administer Mental Health Care Monitoring Teams (CMTs) in NYC that are directly responsible for monitoring the care of high-need individuals and the high-intensity programs (such as Assertive Community Treatment and Intensive Case Management) that serve them, to help improve treatment and services.

- **Create a Database to Track the Mental Health Care Provided to High-Need Adults** – OMH and DOHMH should create a database fully accessible to both agencies of encounters of high-need adults within the public mental health system, enabling the CMTs to track care patterns so that interruptions in care or escalating need for services are better identified and addressed.

- **Implement Family Care Coordinators for Justice-Involved Youth** – Every adolescent with serious emotional disturbance (SED)° in the juvenile justice system should be assigned a

Notes:

6 An adolescent with SED must have a psychiatric diagnosis along with an impaired level of functioning due to the emotional disturbance. A full definition of SED is available at http://www.omi.state.ny.us/omiweb/rtp/2008childrens_community_residences/appendix_c.html.
Family Care Coordinator—until the youth is discharged—to help families navigate the juvenile justice, mental health and other systems and facilitate information sharing among providers and families.

- **Improve Office of Children and Family Services Discharge Planning and Aftercare Services** – Discharge planning should begin within 30 days of admission at a NYS Office of Children and Family Services (OCFS) facility and should engage the youth, family members and community providers. To facilitate discharge planning and aftercare in the community, adolescents should be assigned community service workers—individuals who provide aftercare services and follow-up to collaborate with the Family Care Coordinators.

- **Implement Recommendations of the NYS OMH/Office of Alcoholism and Substance Abuse Services Task Force on Co-Occurring Disorders** – OMH and the NYS Office of Alcoholism and Substance Abuse Services (OASAS) are overseeing implementation of recommendations from a 2007 Task Force on Co-Occurring Disorders that was convened to make improvements in the care for individuals with co-occurring mental health and substance use treatment needs. The Panel supports the Task Force recommendations, which include the issuance of guidelines that call for screening for both mental health and substance use disorders in all clinics that treat these disorders, training for screening, the use of evidence-based treatments and reimbursement for evidence-based integrated treatments.\(^7\)

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2. **Inconsistencies in Quality of Care within the Mental Health Treatment System**

**Recommendations:**

- **Conduct Critical Incident Reviews** – The State should enact legislation to authorize OMH to collaborate with local governments and appropriate State and local agencies to conduct regular, timely reviews of critical incidents involving the care of individuals with mental illnesses. These reviews should aim to reduce care errors and improve safety. Pending statutory changes to authorize this type of multi-agency incident review process, OMH and the local government authority overseeing mental health services (e.g. DOHMH in NYC) should continue to collaborate with each other on the review of critical incidents in compliance with existing law.

- **Issue and Monitor the Use of Standards of Care for Mental Health Clinics** – OMH should issue standards of care—including guidelines for assessing risk of violence to self or others—for mental health clinics serving adults.\(^8\) These standards should also provide guidance on the initial evaluation, ongoing risk assessment and changing treatment plans when an in-
individual's mental health deteriorates. OMH and DOHMH should incorporate these standards into licensing and programmatic reviews.

- **Implement Systemic Improvements to Assisted Outpatient Treatment** – DOHMH should conduct outreach to hospitals to improve the rate of appropriate referrals to Assisted Outpatient Treatment (AOT), clarify and standardize AOT enrollment and renewal criteria, and establish an independent clinical review of decisions not to accept or renew AOT orders.

### 3. Limited capacity to share information within and between the mental health and criminal and juvenile justice systems

**Recommendations:**

- **Pilot a Program for Sharing Information between the Criminal Justice and Mental Health Treatment Systems** – NYS and NYC should pilot an effort to identify individuals with serious mental illnesses who have become involved in the justice system. This information would be shared, with appropriate consent, to facilitate treatment-based alternatives.

- **Increase Information Available to the New York City Police Department** – The NYC Police Department (NYPD) should establish database flags for locations that might trigger dispatch of the specially trained Emergency Service Unit, including locations that have been the subject of prior "emotionally disturbed person" ("EDP") calls and locations of housing with supports for individuals with mental illnesses.

- **Include Information Sharing Protocols in the Standards of Care** – The adult mental health clinic standards of care should include clear guidance for providers regarding communication with other service providers, families and caregivers.

- **Enable Information to Follow Adolescents Through Transition Points in the Juvenile Justice System** – OCFS and the NYC Departments of Probation (DOP) and Juvenile Justice (DJJ) should establish policies to seek consent from parents or guardians to share otherwise confidential information, such as the results of health and mental health screening and assessments, to help determine how to best meet the service needs of adolescents as they move through detention, placement, and aftercare.

- **Increase Monitoring of Individuals Determined to be Not Responsible for Criminal Conduct due to ''Mental Disease or Defect''** – DCJS should provide OMH and the NYS Office of Mental Retardation and Developmental Disabilities with real-time notification of arrests of individuals who have been determined to be not responsible for criminal conduct due to "mental disease or defect" and are in the community subject to court-ordered conditions.\(^9\)

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\(^9\) NYS Criminal Procedure Law § 330.20.
4. Insufficient training, supports and tools to identify and engage individuals with mental illnesses in the criminal and juvenile justice systems

**Recommendations:**

- **Pilot a NYC Alternative-to-Detention Program** – NYC should pilot a new alternative-to-detention (ATD) program with a special mental health track designed to provide assessment, case management, supervision, and community-based treatment to defendants with mental illnesses who might otherwise be detained while their cases are moving through court and who do not pose a high risk of flight or a risk to public safety.\(^{10}\)

- **Create a Dedicated Mental Health Unit at the NYC Department of Probation** – NYC DOP should create a dedicated mental health unit of probation officers with reduced caseloads, who would establish relationships with probationers’ mental health providers and assist probationers in receiving appropriate services.

- **Include Validated Mental Health Screening in Pre-Sentence Investigations** – Pre-sentence investigations conducted by NYC DOP should include a brief, validated mental health screen to allow DOP to alert judges about defendants who may need a more in-depth clinical assessment and may benefit from treatment-based alternatives or special probation conditions.

- **Pilot Mental Health Screening in Criminal Court for Individuals Sentenced to Community-Based Sanctions** – NYC should introduce mental health screening in the Bronx Criminal Court to identify individuals sentenced to brief community-based programs who may benefit from mental health assessments, intensive engagement, and voluntary case management as an alternative to the original court mandate.

- **Expand New Mental Health Courts and Alternatives-to-Incarceration** – NYS should expand the number of mental health courts throughout the State and NYC should expand the number of alternative-to-incarceration (ATI) programs that link offenders to court-monitored mental health treatment as an alternative to traditional case processing.\(^{11}\)

- **Improve Training for 911 Call Takers and Dispatchers** – NYS should create and refer to the NYS 911 Board a training protocol for 911 dispatchers to elicit information about whether a person involved in an incident has a history of mental illness.

- **Sponsor a Statewide Mental Health-Law Enforcement Summit** – NYS should sponsor a Mental Health-Law Enforcement Summit to enhance the relationships between law en-

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\(^{10}\) An alternative-to-detention (ATD) program provides community supervision of a defendant during the period when his/her case is moving through the court. An alternative-to-incarceration (ATI) program provides a community-based sentencing option for judges, in lieu of a jail or prison sentence.

\(^{11}\) See Appendix D for more information on mental health courts in NYS.
forcement and the mental health community. Action Plans will be developed; the Division of Criminal Justice Services (DCJS) will coordinate follow up to assist in implementation.

- **Continue Ongoing Review of Best Practices for Dealing with "EDP" Incidents in NYPD's Training Curriculum** – NYC's Project LINK—an ongoing NYPD and DOHMH effort that includes mental health professionals, consumers, and researchers—should continue to review NYPD’s training curriculum to ensure it reflects current best practices in law enforcement training for dealing with "EDP" incidents.

- **Enhance Clinical Interventions for Youth with SED in DJJ or OCFS Custody** – DJJ and OCFS should incorporate clinical interventions into their systems through several initiatives, including expansion of DJJ’s Collaborative Family Initiative to provide community-based treatment options in lieu of further detention and/or placement in an OCFS facility, and OCFS administration of a Voice-Diagnostic Interview Schedule for Children (V-DISC) and a trauma assessment upon a youth’s entry into care.

The recommendations presented in this report can improve mental health services and criminal justice interactions for individuals with mental illnesses and enhance the safety of these individuals and the public. However, it is important to recognize that even a perfect system would not be able to predict and prevent every violent incident involving a person with mental illness, and individuals may legally refuse care offered to them. Even with improved information sharing, there are substantial limitations to the data that exists and that can be shared, including reporting lags, data quality issues, information that is unavailable on individuals who are not served by public systems of care, and confidentiality issues.

In spite of these limitations, the Panel is confident that with the implementation of the recommendations presented in this report and the ongoing collaboration between State and City officials and the involvement of the community, both public safety and the quality of care for individuals with mental illnesses can be improved.
Panel recommendations grouped by system

**Adult mental health treatment system**
- Establish Care Monitoring Teams to strengthen oversight of high-need adults and high-intensity providers
- Create database to track the mental health care of high-need adults
- Conduct reviews of critical incidents involving the care of individuals with mental illnesses
- Issue standards of care for mental health clinics serving adults
- Implement systemic improvements to AOT to improve outreach, standardize enrollment/renewal, and review decisions not to renew orders
- Implement measures to better identify and enhance care for individuals with co-occurring mental health and substance abuse disorders

**Adolescent system of care**
- Create Family Care Coordinators for justice-involved youth to assist families in navigating the mental health system
- Improve OCFS discharge planning and aftercare services
- Enable information to follow adolescents through transition points in the juvenile justice system
- Enhance clinical interventions for youth with SED in DJJ or OCFS custody
Adult criminal justice system

- Pilot a program for sharing information, with individual consent, between the criminal justice and mental health treatment systems
- Increase information available to NYPD dispatch to allow for specialized responses for incidents involving individuals who may have a mental illness
- Monitor individuals determined to be not responsible for criminal conduct due to “mental disease or defect”
- Pilot a NYC alternative-to-detention program to allow eligible individuals to be supervised in the community while receiving treatment & services
- Create a dedicated mental health unit at the NYC DOP to assist eligible probationers in receiving appropriate mental health treatment services
- Include brief mental health screenings in pre-sentence investigations
- Pilot mental health screenings in the Bronx Criminal Court for individuals sentenced to community-based sanctions
- Expand new mental health courts and alternatives-to-incarceration programs providing court-monitored mental health treatment
- Train 911 call takers and dispatchers to better elicit information about whether an incident involves a person with mental illness
- Sponsor a Statewide Mental Health-Law Enforcement Summit to enhance relationships between police and mental health professionals
- Continue ongoing review of best practices to inform NYPD’s training curriculum for dealing with incidents involving “emotionally disturbed persons”
II. Introduction

In the wake of several recent, highly publicized violent incidents involving individuals with mental illnesses, officials in New York State (NYS) and New York City (NYC) convened a panel to examine these cases, consider opinions of experts and recommend actions to improve services and promote the safety of all New Yorkers.

The NYS/NYC Mental Health and Criminal Justice Panel (Panel) was convened by NYS Deputy Secretary for Health and Human Services Dennis Whalen and NYC Deputy Mayor for Health and Human Services Linda Gibbs. The Panel was co-chaired by NYS Office of Mental Health Commissioner Michael Hogan, NYS Division of Criminal Justice Services Commissioner Denise O’Donnell, NYC Deputy Mayor Linda Gibbs and NYC Criminal Justice Coordinator John Feinblatt. The Adolescent workgroup was co-chaired by NYS Office of Children and Family Services Commissioner Gladys Carrión and NYC Family Services Coordinator Ronald Richter. Members of the Panel included top State and City officials in mental health, addiction, criminal justice and adolescent services.  

The Panel’s work was informed by a review of cases involving individuals with serious mental illnesses and violent behavior, some of which involved engagement with law enforcement officials, as well as a broader assessment of how New York’s mental health and justice systems respond to adults and adolescents with serious mental illnesses. The Panel also consulted with national experts in mental health, violence and the interaction between individuals with mental illnesses and the criminal justice system.

The Panel focused on opportunities to improve services for the subset of individuals with serious mental illnesses who are at risk of poor treatment outcomes, involvement with the justice system, and potential acts of violence. The Panel noted that the vast majority of individuals with mental illnesses are not violent,  

that mental illness is not a major driver of violent crime, 

and that people with mental health needs are far more likely to be victims than perpetrators of violence.

At the same time, research does suggest that the risk of violence is significantly increased among individuals with co-occurring mental health and substance use disorders, especially for those who do not receive coordinated, high quality treatment. Providing effective mental health care for these individuals is critical, as it may significantly mitigate the risk of violence. Research demonstrates that individuals with mental illnesses engaged in regular treatment are no more likely to commit acts of violence than the general population, and are

Notes
12. See Appendix A for Panel membership list.
15. Ibid Pandi et al. 2007.
considerably less likely to commit violent acts than those who could benefit from, but are not engaged in, appropriate mental health treatment.¹⁶

This report, which reflects collaboration between State and City officials, summarizes the Panel's findings and recommendations. Through ongoing collaboration, and the involvement of the community, the Panel believes that essential improvements in the engagement and care of people with mental illnesses can be achieved, thereby benefiting the safety and well being of both these individuals and the public.

Notes
III. Background on New York State’s mental health and criminal justice systems

Mental illness is prevalent and often untreated or poorly treated. In the United States, 50% of individuals will experience a mental disorder sometime in their lifetime\(^{17}\) and more than 20% will be affected annually;\(^{18}\) in addition, 3-5% of adults and children will have a mental illness severe enough to cause major disability. Yet fewer than half of the people who experience a mental illness will receive care, according to recent studies, and only half of the care by mental health specialists – and far less of the mental health treatment in the general health system – is clinically adequate. Delays in receiving care are also common – the average age of onset for a mental disorder is 14 years, while the average lag from first symptoms to receiving care is 9 years.\(^{19}\)

Individuals with mental illnesses in NYS face challenges that are similar to, and sometimes more profound than, those found elsewhere in the United States. While dedicated clinicians and programs provide high quality care to hundreds of thousands of New Yorkers with mental illnesses every year, NYS’ mental health system is exceptionally large, and it is therefore quite difficult to track and facilitate access to quality care for those most in need. Families provide much of the needed support for relatives with mental illnesses, yet they frequently struggle in isolation from other caregivers.

To live successfully in the community, individuals with serious mental illnesses, with or without involvement with the criminal justice system, need effective treatment for their illnesses and a range of recovery-based services. For many individuals, effective counseling and/or medication provided in clinics can be sufficient. For individuals with more complex conditions, greater disability and multiple challenges, well-coordinated care that knits the pieces together is essential. In addition to counseling and medication treatment, this care may include housing (with or without supervision), rehabilitation and employment supports, careful monitoring, and well-charted “hand-offs” if hospitalization is necessary.

Furthermore, people with mental health and substance use disorders cannot fully recover and lead productive lives in the community without safe and reliable housing, and employment or

Notes

other meaningful social roles. Yet finding suitable housing is particularly difficult because of New York's high housing costs coupled with large numbers of low-income people with disabilities and numerous obstacles to competitive employment.

NYS' law enforcement, courts and corrections agencies also struggle to meet the needs of the tens of thousands of adults with mental illnesses who touch the City and State criminal justice systems each year. Similarly, the juvenile justice system has focused increasing attention in recent years on the high incidence of mental disorders – including serious emotional disturbance (SED) – among justice-involved youth.

The following sections provide background on how the mental health system in New York is configured and how the criminal and juvenile justice systems interface with and respond to individuals with mental illnesses.

A. The NYS mental health system

The NYS Office of Mental Health (OMH) funds, licenses and operates a statewide system of care for people with mental illnesses, especially adults with serious mental illness and children with SED – those individuals with the most difficult and complex conditions.

In NYC, the Department of Health and Mental Hygiene (DOHMH) also administers this safety net. DOHMH is responsible for, among other things, planning and contracting for mental health services. Its responsibilities also include directing and operating the Assisted Outpatient Treatment (AOT) program and administering a system to facilitate the removal of individuals with mental illnesses under an AOT order who may be a danger to themselves or others to emergency rooms for evaluation for hospital admission.

The public mental health system in NYS includes OMH, DOHMH and other local government units, licensed and unlicensed programs, inpatient hospital and outpatient and community-based agencies that serve more than 600,000 New Yorkers annually. Multiple State, City and county agencies share responsibility for those individuals receiving services and the 2,500+ community-based mental health programs and providers of rehabilitative services and housing who care for them. OMH also operates the nation's largest network of state-operated inpatient facilities for children, adults and forensic clients.

Like other states, but to a greater degree, NYS has turned to Medicaid to finance mental health care, and the Medicaid program is now the State's largest payer of mental health services. While the State benefits from this approach by securing federal financial support for mental health services, using Medicaid funding to this degree has its drawbacks, including the fact that many people do not qualify for the program and essential services such as employment and housing are not covered.
B. New York States' Assisted Outpatient Treatment (AOT) and inpatient commitment laws

In 1999, NYS enacted legislation that authorizes courts to order AOT for certain individuals with mental illnesses who are unlikely to survive safely in the community without supervision. Commonly referred to as "Kendra's Law," the AOT program focuses on individuals whose non-adherence to treatment has resulted in repeated hospitalization or has led to threats or acts of violence, and who would likely deteriorate without AOT. Passage of the AOT statute was accompanied by significant funds to expand case management and other services for individuals on AOT.

An AOT order is issued by a court and requires an individual to engage in outpatient treatment with an assigned provider – such as case management services, a clinic, or Assertive Community Treatment (ACT) – that provides a variety of treatments such as individual or group therapy, substance abuse treatment, and medication monitoring. Local counties and NYC have the responsibility for seeking court approval for AOT orders and monitoring the services provided. A court may renew an AOT order and may determine the length of renewal. AOT teams may choose not to petition for renewal of an order if the person's condition has improved or if the person is considered not to be benefiting from AOT. Even after an order has ended, a person can still receive services from the team of professionals originally assigned to the individual, but the AOT program would not monitor either the services or the individual.

AOT has proven to be effective for many people who receive these services. OMH has engaged an independent research team to evaluate the program, which should help clarify whether its effectiveness is attributable to better access to services for individuals on an AOT order or to the mandatory nature of the services; that report is due in 2009.

With respect to non-emergency involuntary inpatient commitment, NYS has one of the broadest involuntary commitment laws in the United States. While many states require that there be a finding of "imminent" or "immediate" danger to self or others in order to involuntarily commit an individual to a psychiatric hospital on a non-emergency basis, NYS' standard for non-emergency, involuntary hospitalizations does not require a finding of "imminent" or "immediate" danger.

Notes
20 NYS Mental Hygiene Law (MHL) §9.60
22 NYS Mental Hygiene Law (MHL) §9.27
C. The NYS criminal and juvenile justice systems

Each year, thousands of people with serious mental illnesses touch the State and City criminal justice systems. While the inmate census in NYS correctional facilities has declined steadily over the past three years to approximately 63,000 inmates currently, the percentage of inmates diagnosed with mental health needs has increased by 15% in that same period. Approximately 8,500 inmates, or 13.5% of the State's inmate population, receive mental health services every day.

In NYC, a study of individuals arrested in Brooklyn found that 18% had a serious mental illness and, according to DOHMH, on any given day there are roughly 2,500 individuals with mental health problems in the City's jails. Of these, approximately 800 are housed in dedicated mental observation units. NYC police, who respond to 4.5 million 911 calls annually, receive nearly 90,000 calls every year regarding an "emotionally disturbed person" ("EDP") – though only approximately 1% of these calls lead to an arrest.

Studies indicate that youth in the juvenile justice system are more likely to be diagnosed with SED (20%) than youth in the general population (9-13%). OCFS found that in 2003, 53% of young people entering placement facilities needed mental health services, and the NYC Department of Juvenile Justice (DJJ) reported that 67% of detained youth received mental health services in 2007.

NYC and NYS law enforcement, courts and corrections agencies struggle to meet the needs of these individuals. Over the past decade, NYS' criminal justice system, in collaboration with the Office of Court Administration, has developed an increasing network of mental health courts and alternative-to-incarceration (ATI) programs that link offenders to court-monitored mental health treatment, often in lieu of jail or prison. In addition, NYS has nearly doubled its corrections-based mental health staff over the past decade. Similarly, City and State officials have responded in recent years to the high incidence of mental disorders among youth in the juvenile justice system with new programs, services, and supports.

Law enforcement agencies throughout the State, too, recognize the need to train officers to respond appropriately to individuals deemed to be "EDPs." The State has mandated a 14-hour mental health training curriculum for new police recruits around the state. This has been supplemented by increasing amounts of in-service training for veteran officers and specialized training for officers who respond to "EDP" calls, including use of the Crisis Intervention Team (CIT) model.

Notes
25 See Appendix D for more information about mental health courts in NYS
IV. Findings and recommendations

As noted previously, in developing its findings and recommendations, Panel members reviewed several cases involving high-need adults with serious mental illnesses and adolescents with SED who came into contact with the criminal and juvenile justice systems.26 The members of the Panel also called upon their own expertise and experience to conduct a broad assessment of the mental health and justice systems, and obtained input from national experts about the state of the art in mental health treatment, risk assessment and the intersection of mental health and criminal justice.

National experts with whom the Panel consulted point to data indicating that people with mental illnesses receiving appropriate care commit violent acts at a rate slightly below that of the general population and account for a very small proportion of serious crimes.27 The research also suggests, however, that violence among people with serious mental illness increases if they abuse alcohol or drugs, and that this risk is compounded if they fail to get treatment or receive inadequate care.28 Thus, the Panel concluded that the best way to improve outcomes and safety for high-need adults with serious mental illnesses and adolescents with SED is to take concrete steps to provide people with mental health needs appropriate, coordinated services.

Panel members identified many ways in which both the mental health and criminal justice systems could improve their ability to help adults and adolescents with serious mental illnesses. The challenges, which were identified through the case reviews and the Panel’s broader assessment of the mental health and criminal justice systems, fall into four broad categories: 1) poor coordination, fragmented oversight and lack of accountability in the mental health treatment system; 2) inconsistencies in quality of care within the mental health treatment system; 3) limited capacity to share information within and between the mental health and criminal or juvenile justice systems; and 4) insufficient training, supports, and tools to identify and engage individuals with mental illnesses in the criminal and juvenile justice systems.

Specifically, the cases examined by the Panel revealed poor accountability and weak integration or communication among mental health, substance abuse and correctional services, even in instances where individuals were assigned the highest intensity community-based services, such as ACT – a proven community-based intensive treatment for those with complex needs and difficulty engaging in traditional treatment.

Notes
26 To comply with State and federal laws regulating the disclosure of personal health information, this Report does not include identifying information about any particular case.
27 Ibid Monahan et al. 2001
28 Ibid Monahan et al. 2001; Ibid Swanson et al. 2002
Though families are often critical sources of information, important aides in coordinating and overseeing care, and vital supports in the demanding work of recovery and treatment, the cases revealed that family members were not effectively engaged in the treatment process.

Limited capacity to share information within and between the mental health and criminal and juvenile systems was also evident in the cases the Panel reviewed. Information sharing may have helped both clinicians and criminal and juvenile justice professionals make more informed and better decisions. The Panel's review also included police training and the need for law enforcement to have access to information that can help them respond more effectively to encounters with individuals with serious mental illness. The Panel also noted that the criminal justice system as a whole has limited ability to identify individuals who might benefit from mental health treatment and services as an alternative to traditional criminal justice processing.

The cases revealed problems and challenges common to many individuals with mental illnesses, including lack of safe and affordable housing and difficulty securing employment or other meaningful social roles. In discussing these broader challenges and their impact on the cases reviewed, the Panel recognized many efforts currently underway to address these issues, though these issues were not the focus of the Panel's work.

The Panel focused on core problems in the mental health and criminal and juvenile justice systems regarding the care and treatment of people with complex and serious mental health needs. Because the Panel focused on areas where there was room for improvement, this report does not detail the extent to which thousands of mental health and criminal and juvenile justice professionals are dedicated to ensuring both public safety and the well-being of individuals with mental illnesses.

**Finding: Poor coordination, fragmented oversight and lack of accountability in the mental health treatment system**

In the cases it examined, the Panel saw tragic outcomes resulting from fragmented care and a failure to detect and respond to signs of inadequate care, deterioration in mental health, and increasing signs of potential violence.

Coordination between service providers is a critical component of effective treatment, yet the Panel noted that mental health providers often act in parallel, rather than in concert. Further, individuals who need high-intensity services do not always have a care provider who is primarily responsible and accountable for all aspects of the individual's care and with whom the individual is in regular communication. Such a provider must take action when care is failing or when the individual shows signs of clinical deterioration or disengagement from care.
The Panel also noted that individuals with co-occurring substance use disorders and mental illnesses lack access to and information about treatment, and too few providers offer coordinated, evidenced-based integrated care for these conditions, severely limiting an individual's capacity to recover.

The Panel observed that care is often provided to individuals by multiple agencies, and that these agencies too often do not effectively communicate with other treating agencies, hospitals or involved families. In such cases, care is often poorly coordinated and information gaps often inhibit the ability to provide needed services effectively. In addition, there are overlapping responsibilities and a lack of accountability for monitoring either the individuals receiving intensive services or the providers that treat them.

The same lack of communication, coordination and accountability is evident in the care provided to adolescents with SED in the juvenile justice system, especially when youth transition in and out of the system. Care providers do not routinely communicate with one another and review each others' records so that the youth's treatment plan reflects prior treatment successes or failures. Often, there is also inadequate coordination among the NYC Department of Probation (DOP), DJJ, and OCFS, and even within OCFS facilities, as well as with community-based aftercare providers. Furthermore, the Panel reviewed evidence that suggested that families with children in the juvenile justice system are not consistently engaged in their children's care, including in the creation and realization of treatment and discharge plans. Finally, discharge plans for those aging out of the OCFS system do not always provide for consistent aftercare services that are essential for successful re-entry into families and the community.

**Recommendations**

Establish care monitoring teams for high-need adults

OMH and DOHMH should jointly establish and administer Mental Health Care Monitoring Teams (CMTs) in NYC, potentially at the borough level, to be directly accountable for monitoring the care of high-need individuals and the programs that serve them, such as ACT and Intensive Case Management. Although the primary responsibility for coordinating care and communicating with different treatment providers and families should rest with an individual's primary provider and other providers on the team (as detailed in the standards of care section that follows), the CMTs would play an important role in facilitating coordinated care and improving services. In addition, OMH and DOHMH should explore peer-based services and efforts that encompass goals specifically identified by individuals with mental illnesses – such as assistance with housing and benefits, as well as recovery-oriented treatment plans – in an effort to improve the ability to engage and retain individuals in services.
Create a database to track the mental health care provided to high-need adults

CMTs should have a database of information to better monitor the care provided to high-need individuals in the public mental health system. This database will help identify and address interruptions in care or the need for escalating care and will be populated initially with existing data – including Medicaid claims, with federal approval. This database could also assist in improving service delivery to those in emergency or crisis situations and to inform decisions made by mental health professionals that evaluate or treat individuals. Finally, the database can help individuals receive proper treatment once they come into contact with the criminal justice system (see recommendations that follow for an information sharing pilot).

Implement Family Care Coordinators for Justice-involved youth

Adolescents with SED in the juvenile justice system should be assigned a Family Care Coordinator – an individual with first-hand experience with the child or adolescent mental health system – who would follow that youth from entrance into the justice system until the youth is discharged. The Coordinator would help families navigate the juvenile justice, mental health and other service systems; facilitate information sharing among providers and families; and arrange for family case conferences that assist youth and their families in getting care and support, especially during transitions. Coordinators would use their own experiences negotiating the mental health system and other systems to empower families to advocate for their own needs. The Coordinator would also arrange "circles of support" – facilitated meetings where individuals who share similar challenges gather to provide mutual support – for families of youth with SED who are in the custody of DJJ or OCFS.

Improve OCFS discharge planning and aftercare services

Discharge planning should begin within 30 days of admission to an OCFS facility and should engage the youth, family members, and community providers. To facilitate discharge planning and aftercare in the community, adolescents should be assigned community service workers – individuals who provide aftercare services and follow-up – to collaborate with the Family Care Coordinators.

As youths are discharged from OCFS-provided services, referrals should be made (and confirmed) to specific community-based mental health services such as waiver programs, outpatient clinics, day treatment programs, and intensive mental health programs. Community service workers and Family Care Coordinators should connect youth approaching age 18 to appropriate adult mental health services. In addition, AOT petitions should be initiated for youth who are 18 or older who do not voluntarily engage in treatment and who meet AOT eligibility criteria.
Implement recommendations of the NYS OMH/OASAS Task Force on Co-Occurring Disorders

OMH and the NYS Office of Alcoholism and Substance Abuse Services (OASAS) are overseeing implementation of recommendations from a 2007 Task Force on Co-Occurring Disorders that was convened to make improvements in the care for individuals with co-occurring mental health and addiction treatment needs. The Panel supports the Task Force recommendations as important steps to expand access to integrated treatment for co-occurring mental health and substance use disorders. The recommendations include the issuance of OMH/OASAS advisory guidelines that call for screening for both mental health and substance use disorders in all clinics that treat these disorders; training in screening and evidence-based treatments for community-based providers; outreach to mental health and substance use treatment providers to help them understand the regulatory opportunities for providing integrated co-occurring disorder care; reimbursement for evidence-based integrated treatment; and the promotion of local innovation in the treatment of co-occurring disorders.29

Finding: Inconsistencies in quality of care within the mental health treatment system

In reviewing the cases, the Panel noted that while individuals with a serious mental illness were often enrolled in clinic-based mental health care, treatment providers did not consistently follow widely accepted – but not explicitly stated – standards of clinical care that describe quality care for recipients and their families. For example, good clinical practice and a body of literature on mental health and substance use treatment stress the need for thorough and timely psychiatric, substance use and medical evaluations. Good clinical practice also calls for assessing an individual’s degree of dangerousness to self or others, engaging family and significant others as key partners and supports, and responding appropriately when individuals disengage from their established treatment plans, including medication. In addition, quality care is dependent on appropriate caseloads and supervision, especially of inexperienced professional staff.

With respect to AOT, the Panel reviewed evidence that suggests that individuals on AOT often do quite well while they are engaged in services, but access to and discharge from AOT is not sufficiently standardized or reviewed. For example, the Panel noted during the case reviews that during the time when some individuals receive court-ordered services the individual and the provider are both engaged in the treatment process. However, when the order is allowed to expire, there are failures to provide follow-up care, often resulting in lapses in care.

In the course of its work, the Panel also recognized the value of reviewing representative incidents and "near misses" to identify failures in the provision of care as well as quality improvement steps

Notes

29 See Appendix C for more information on the Task Force for Co-Occurring Disorders and its recommendations
that can be taken to mitigate future incidents. Yet New York has no protocol for conducting regular, system-level quality assurance reviews of critical incidents involving individuals with mental illnesses with multiple city and state agencies and community providers.

**Recommendations**

**Conduct critical incident reviews**

NYS should enact legislation to establish a protocol that will allow OMH officials to collaborate with local governments to conduct timely reviews of critical incidents involving the care of individuals with serious mental illnesses. These case-specific, multi-agency reviews should aim to reduce care errors and improve the safety of the public as well as individuals who need mental health care. This critical incident review process will serve as an ongoing quality assurance mechanism. Pending statutory changes, OMH and the local government authority overseeing mental health services (e.g. DOHMH in NYC) should continue to collaborate with each other on the review of critical incidents in compliance with existing law.

**Issue and monitor the use of standards of care for mental health clinics**

OMH, in consultation with DOHMH, should develop, issue, conduct training on and monitor the use of standards of care for all licensed adult mental health clinics. The standards should be drawn from a body of clinical knowledge, training and professional publications and address issues such as initial evaluation, coordination with case management and other services, ongoing risk assessment, and changing treatment plans when an individual’s mental health deteriorates or he or she is not engaged in care. The standards should also provide clear guidance about appropriate caseload levels and communication with other providers, families and other caregivers. These elements of quality care are more explicitly described for other mental health services but not for clinics, where most people receive care and where staff members are positioned to identify and intervene earlier in the course of treatment with high-need individuals.

Because quality care for individuals with serious mental illnesses involves a thorough understanding of and focused response for the management of identified risk factors, a critical component of the standards of care for individuals with mental illnesses is conducting initial and ongoing risk assessments. Risk assessment is a sequential process that begins with obtaining information from the individual and collateral sources regarding any history of violent thoughts or behavior and includes identification of factors that increase risk, such as the presence of a co-occurring substance use disorder. An assessment and recognition of the factors that influence risk should be used to guide the development of an individualized plan, prepared jointly by the

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**Notes**

30 See Appendix E for Guidelines for Mental Health Clinic Standards of Care and Sequential Screening of Risk for Violence.

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clinician and the individual. After treatment begins, risk assessments should be performed at various junctures in the treatment process, including discharge from treatment or when there are indications that the treatment plan is failing.

To monitor that these standards are implemented in the course of treatment, OMH and DOHMH should incorporate a review of adherence to the standards into licensing and programmatic reviews. The Panel notes that previously planned increases in reimbursement for clinic care could be introduced to coincide with the issuance of these standards.

Implement systemic improvements to Assisted Outpatient Treatment

The Panel chose not to recommend any statutory changes to AOT while the program is being examined, although some improvements can be made in advance of the study's release, specifically regarding AOT renewals. The Panel recommends that DOHMH continue its increased effort to conduct outreach to hospitals to improve the rate of appropriate referrals, clarify and standardize AOT enrollment and renewal criteria, and establish an independent clinical review of decisions not to accept or renew AOT orders. OMH, DOHMH, and the NYC Criminal Justice Coordinator (CJC) should work collaboratively with the Office of Court Administration to explore specialized judicial assignments for AOT cases and to continue to provide training to those involved with individuals on AOT.

Finding: Limited capacity to share information within and between the mental health and criminal and juvenile justice systems

The Panel reviewed evidence that suggests that information related to an individual's treatment often is not transmitted, shared, or made available between care providers, leading to poor care coordination and lack of continuity of care. For example, critical information is often not shared during transitions (e.g., from hospital to clinic) or between providers treating the same person. Similarly, important treatment and educational records do not typically follow adolescents through the juvenile justice system and when youth transition into and out of that system. The Panel also noted that clinicians in emergency departments often lack prior treatment records that would help them to make accurate diagnoses and determine appropriate treatments. Complicating matters further, available mental health data is not organized in a way that enables effective oversight and receipt of needed care.

Pursuant to the standards of care outlined previously, important aspects of individuals' previous treatment as well as relevant information from families can and should be transmitted between clinical programs treating the same individual – especially hospitals, emergency departments, and community-based mental health and substance use treatment programs – to
the fullest extent allowable by law. Yet the Panel noted that consumers, providers, and families are often unsure about what can be appropriately disclosed to facilitate the provision of good care.

The Panel noted that emergency 911 call takers statewide do not generally elicit information about whether mental illness is relevant to a 911 call. This information could be used to determine when to deploy specialized resources.

More fundamentally, the Panel discovered that there is very limited capacity to share information between the mental health and criminal justice systems, even when information could help ensure continuity of care and help justice officials determine when an individual may be appropriate for a treatment-based alternative. In practice, this has been difficult primarily for three reasons:

◆ Privacy laws intended to safeguard personal health information effectively prohibit disclosure to entities other than treatment providers, absent an individual’s consent to disclose such information.

◆ The criminal justice system lacks mechanisms to routinely screen for mental illnesses and elicit defendants’ consent for the sharing of relevant mental health information.

◆ Criminal justice and mental health data systems lack the ability to facilitate the cross sharing of information, regardless of whether that information is publicly available or made available through consent.

In its exploration of this issue, the Panel considered recommending statutory changes to permit limited mental health information sharing with the criminal justice system without the consent of the involved individual for the purpose of ensuring continuity of care and referrals to ATI programs. Such legislation would recognize that the criminal justice system can serve as a successful gateway into treatment, since it is often a point of contact for individuals whose mental health is deteriorating because of inadequate, or lack of, treatment. Improving information sharing between the mental health and criminal justice systems could result in more successful collaborative efforts to prevent individuals with serious mental illnesses from cycling repeatedly through the criminal justice system.

Several valid concerns were raised about this option, however – including that information sharing could potentially stigmatize individuals with mental illnesses and lead to punitive criminal justice system responses, raise privacy concerns, and significantly alter current practice. The Panel recommends several pilot projects (detailed in this and the following section), designed to identify individuals with mental illnesses in the criminal justice system who might be linked to long term services through the criminal justice system. The results of these programs should be closely monitored and officials from the mental health and criminal justice systems should continue to discuss this issue, including the possible need for a legislative solution in the future.
Recommendations

Pilot a program for sharing information between the criminal justice and mental health treatment systems

NYS and NYC should pilot an effort to identify individuals with serious mental illnesses who have become involved in the justice system in order to determine whether they may be appropriate for mental health treatment-based alternatives. Specifically, as part of the CMT’s responsibilities (discussed previously), a member of the team would track arrests through an exchange of data and notify community mental health providers and case managers that an individual has been arrested – facilitating continuity of care, including jail-based treatment and discharge planning. The CMT liaison would also facilitate eliciting consent to share otherwise confidential information about mental health history and status with criminal justice professionals for purposes of treatment-based alternatives.

Increase information available to the NYPD

The NYPD should establish flags within its 911 database for locations that might trigger the dispatch of the specially trained Emergency Service Unit, including locations that have been the subject of prior “EDP” calls and locations of housing with supports for individuals with mental illnesses.

Include information sharing protocols in the standards of care

The standards of care that the Panel recommends previously should include clear guidance for providers regarding appropriate and effective communication with other service providers, families and other caregivers.

Enable information to follow adolescents through transitions in the juvenile justice system

NYC DOP, DJJ and OCFS should establish policies to seek consent from parents to share otherwise confidential information—such as the results of mental health screening and assessment–to help determine how best to meet the service needs of adolescents as they move through detention, placement, and aftercare. Policy and procedures should be established by which all mental health caregivers for children will provide information, with appropriate consent, to DJJ clinicians about the ongoing treatment and clinical needs of youth in their care immediately upon learning that a juvenile has entered DJJ care. City and State agencies will advance training for child mental health providers on these policies and procedures.
Increase monitoring of individuals determined to be not responsible for criminal conduct due to "mental disease or defect"

Every year, approximately 30 individuals across NYS are determined to be not responsible for criminal conduct due to "mental disease or defect" and are committed to the custody, or subject to the jurisdiction, of either OMH or the NYS Office of Mental Retardation and Developmental Disabilities.31 DCJS should provide these agencies with real-time notification of arrests of such individuals who are in the community and subject to court orders of conditions.

**Finding: Insufficient training, supports and tools to identify and engage individuals with mental illnesses in the criminal and juvenile justice systems**

As discussed in the previous section, court officials have limited tools with which to access information that could help them assess whether a defendant has a mental illness. This information can help justice professionals determine whether a defendant is an appropriate candidate for a short voluntary treatment program, an alternative-to-detention (ATD) or ATI program, or specialized services while under probation supervision. The Panel also noted that access to such treatment-based programs and services is expanding but still limited in some areas.

The Panel discovered that emergency call takers and dispatchers statewide are often not trained to routinely elicit information about whether mental illness is relevant to a 911 call. This may result in police officers failing to notify and activate specialized mental health care response teams.

**Recommendations**

**Pilot a NYC alternative-to-detention program**

NYC should pilot a new ATD program with a special mental health track, designed to provide assessment, case management, supervision, and community-based treatment. The ATD program should target defendants who are likely to be detained in jail while their case is pending and who do not pose a high risk of either recidivism or flight. Such a program will also help judges assess whether an individual is an appropriate candidate for a treatment-based alternative in lieu of a jail or prison sentence. Piloting this program on a small scale will allow NYC to determine whether participation in a court-monitored community supervision program can reduce recidivism among offenders with mental illnesses.

**Notes**

31 NYS Criminal Procedure Law 330.20
Create a dedicated mental health unit within the NYC Department of Probation

NYC DOP should create a dedicated mental health unit of probation officers with reduced caseloads who would establish relationships with their probationers' mental health providers, assist probationers in receiving appropriate services, and provide closer supervision. These officers should receive special training in handling high-risk individuals with mental illnesses who are on probation. To ensure that this unit has ongoing support, DOHMH should establish an official liaison to DOP, to assist and advise probation officers about the most appropriate community treatment settings for their probationers, provide ongoing trainings, and serve as a point of reference for questions about the mental health care and substance abuse treatment systems.

Include validated mental health screening in pre-sentence investigations

Pre-sentence investigations conducted by NYC DOP should include a brief, validated mental health screen, to allow DOP to alert judges about defendants who may need a more in-depth clinical assessment and may benefit from treatment-based alternatives or special probation conditions. The screen should be piloted in the Bronx to test its efficacy in identifying offenders with mental illnesses and promoting linkages to treatment.

Pilot mental health screening in criminal court for individuals sentenced to community-based sanctions

NYC should introduce post-arraignment mental health screening in the Bronx Criminal Court to identify appropriate individuals, sentenced to brief community-based programs, for mental health assessments, intensive engagement, and voluntary case management as an alternative to the original court mandate. This pilot would help evaluate whether brief mandatory engagement efforts promote longer-term participation in mental health services.

Expand new mental health courts and alternatives-to-incarceration

The State should open mental health courts in seven additional counties during the coming year. NYS and NYC should also expand the number of ATI programs that link offenders to court-monitored mental health treatment as an alternative to traditional case processing.32

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Notes

32 See Appendix D for more information on mental health courts in NYS.

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Improve training for 911 call takers and dispatchers

NYS should create and refer to the NYS 911 Board—which is responsible for promulgating 911 standards—a training protocol for 911 dispatchers to elicit information about whether a person involved in an incident has a history of mental illness.

Sponsor a statewide mental health-law enforcement summit

NYS should sponsor a Mental Health-Law Enforcement Summit to enhance the relationships between law enforcement and the mental health community statewide. Each participating jurisdiction should provide a preliminary action plan at the close of the summit that addresses the criminal justice and mental health issues identified by the jurisdiction and proposes pragmatic solutions. DCJS will coordinate follow up with the jurisdictions to assist in the implementations of these action plans.

Continue ongoing review of best practices for dealing with "EDP" incidents in NYPD's training curriculum

NYC’s Project LINK—an ongoing NYPD and DOHMH effort that includes mental health professionals, consumers, advocates and researchers—should continue to review NYPD’s training curriculum so that it reflects current best practices in law enforcement training for dealing with "EDP" incidents.

Enhance clinical interventions for youth with SED in DJJ or OCFS custody

DJJ and OCFS should incorporate clinical interventions into its systems through several steps, including 1) expansion of DJJ’s Collaborative Family Initiative to provide community-based treatment options in lieu of further detention and/or placement with the State; 2) OCFS administration of a Voice-Diagnostic Interview Schedule for Children (V-DISC) and a trauma assessment instrument upon a youth’s entry into care; 3) the use of evidence- or consensus-based treatments at OCFS facilities; and 4) a three-year OCFS phase in of the Sanctuary model, which provides a safe and therapeutic environment for youth and staff.
V. Conclusion

The recommendations presented in this report can improve mental health services and justice system interactions for individuals with mental illnesses, especially for high-need populations, and enhance the safety of these individuals and the public. However, it is important to recognize that even a perfect system would not be able to predict or prevent every violent incident involving a person with mental illness. Even with improved information sharing, there are substantial limitations to the data that exists and that can be shared. For example, there are confidentiality concerns, reporting lags, data quality issues, and limited information on individuals who are not served by public systems of care. Furthermore, even with accurate and timely information, the tools and existing services for intervention are often limited. A significant number of people with serious mental illness may refuse – and have a right to refuse – high-intensity community-based services. In spite of these limitations, the Panel is confident that with the implementation of the recommendations presented in the report, the ongoing collaboration between State and City officials, and the involvement of the community, public safety and the quality of care for persons with mental illnesses can be improved.
APPENDIX A: Panel membership

Co-Chairs:
John Feinblatt, NYC Criminal Justice Coordinator
Linda L. Gibbs, NYC Deputy Mayor for Health & Human Services
Michael F. Hogan, Ph.D., Commissioner, NYS Office of Mental Health
Denise E. O'Donnell, Commissioner, NYS Division of Criminal Justice Services

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Gladys Carrión, Commissioner, NYS Office of Children and Family Services
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Panel and Workgroup Members:
Karen Friedman Agrifillo
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Bernard Wilson  
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APPENDIX B: Community mental health incident review process

As noted in the report, the Panel recommends the creation of a collaborative, multi-agency quality review process to examine system-level problems in care. The broad delegations of authority given to the Commissioner of OMH under the Mental Hygiene Law could be invoked to establish his authority to convene such a group with other State and City agencies.

In addition, the State should pursue legislation to allow the Commissioner to establish multi-agency review panels to perform detailed, retrospective reviews of serious incidents or "near misses" that merit attention and may provide opportunities to prevent similar incidents from occurring in the future as well as opportunities to improve the care of people with mental illnesses in NYS. Pending statutory changes to authorize this type of multi-agency incident review process, OMH and the local government authority overseeing mental health services should continue to collaborate with each other on the review of critical incidents in compliance with existing law. Following is a description of the two levels of reviews.

1. System-level review process

Under current law, OMH should establish a collaborative process that includes State and City (or county) officials to review aggregate, systems-level data and make recommendations for actions that can be taken to improve the public mental health care system. Such a process should include consideration of the unique issues that arise when individuals with serious mental illnesses interact with the criminal justice system. The goals of this collaborative process will be to identify problems or gaps in service delivery systems and to identify needed systems changes to further improve individual and public safety.

The process should focus on improving the delivery and continuity of mental health care in the community, rather than on identifying deviations by a particular provider or individual from proper and accepted practices. However, if quality problems of particular programs are identified by the reviews, OMH is authorized under current law to take actions regarding the licensure of a particular provider and/or to refer the issue to other responsible parties to investigate and to take appropriate action.
2. Incident review process

NYS should seek passage of legislation that would establish a process to permit the Commissioner of the NYS Office of Mental Health (or designee) to convene an appropriate group of State and local officials, including those from mental health, criminal justice and other agencies, to review the circumstances and services surrounding a serious incident in the community involving a person with mental illness. Exercise of this convening authority would be prompted by events meeting certain pre-established criteria, such as when a person with a serious mental illness is harmed or causes harm to others, or becomes involved in a violent incident. Safeguards should be included to protect individual privacy and medical confidentiality, while at the same time enabling all parties to discuss the incident candidly and without fear that their discussions will become public and subject to discovery as part of court proceedings.

Such a statute should identify specific entities that could be convened, but should indicate that the specific composition of a particular review would depend on the nature of the incident to be reviewed, including the location of the incident and the pertinent entities. All incident review panels should include representatives from OMH and the local government authority overseeing mental health services where the incident took place (e.g. DOHMH in NYC); other entities, such as mental health providers, schools, hospitals, law enforcement and others could be selected to participate in the review of any given incident, as well.

The intent of such incident reviews would be to identify problems or gaps in service delivery systems that could be addressed by corrective action. If quality problems concerning particular programs or individuals are identified based on such a review, OMH should refer the issue identified to the responsible parties to investigate and take appropriate action. In addition, if the review of a particular incident identifies non-performance by a particular organization or entity, the Commissioner (or designee) should have the ability to make such a finding and to call on the entity to take corrective action. This function underlines the importance of the ensuring the confidentiality and protecting from discovery the proceedings of this review process.
APPENDIX C: Co-occurring disorders

In September 2007, OMH Commissioner Hogan, and OASAS Commissioner Karen Carpenter-Palumbo accepted the report of a statewide Task Force charged with providing meaningful, measurable, and actionable recommendations that could be implemented in a timely manner to improve the care of people with co-occurring mental health and substance abuse disorders.

In any given year an estimated 160,000 adults in NYS have a co-occurring serious mental illness and substance abuse disorder. Access to care and quality of treatment are often poor. Nationally, 50 percent of individuals with co-occurring serious mental illnesses and substance use disorders receive no care; 45 percent receive poor care; and only about five percent receive evidence-based care. NYS is taking strong steps to ensure that providers screen and assess for co-occurring disorders in all relevant settings and provide access to integrated care.

The Task Force identified opportunities to eliminate limitations and barriers in accessing care. In addition, the Task Force recommended ways in which to create recovery-oriented care that is hopeful and consumer-driven; recognizes the essential role of family, relationships, community and employment in fostering the quality of life; and, is culturally and linguistically competent. These agreed-upon values are to assure that clients can: Access care anywhere in OMH and OASAS-licensed programs; receive one evaluation; learn if they have a co-occurring disorder; learn about treatment options; collaborate in establishing a single treatment plan; receive evidence- or consensus-based treatment; and, participate in recovery-oriented care.

Following the acceptance of the report by the Commissioners, an implementation group has continued to work on an action plan that will be launched this year that will include the following steps:

- Advance clinical practices that integrate treatment for co-occurring disorders through issuance of guidelines for screenings in all clinics, comprehensive assessments for those who screen positive, and the use of evidence-based treatments
- Educate providers about regulations affecting the provision of integrated treatment
- Allow reimbursement for evidence-based integrated treatment
- Promote local innovation in the treatment of co-occurring disorders.

The full Co-occurring Disorders Task Force Report is available at:
http://www.omh.state.ny.us/omhweb/News/COD_TASK_FORCE_REPORT_FOR_RELEASE.html

Notes


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APPENDIX D: Mental health courts in New York State

Mental health courts are specialized dockets that link defendants with mental illnesses to court-supervised, community-based treatment in lieu of traditional case processing. These courts are based on the concepts of therapeutic jurisprudence and are often modeled on drug courts. Therapeutic jurisprudence has its roots in the analysis of developments in mental health law. One of the leading architects of this concept, David Wexler, describes it as "the study of the role of the law as a therapeutic agent." In practice, the application of therapeutic jurisprudence means incorporating both legal and therapeutic goals in response to violations of the law. Treatment is not prioritized over the requirements of the legal system, but rather integrated into its very processes. Thus, mental health courts are a prime example of therapeutic jurisprudence in action.

While the development of Mental Health Courts has been on a significant upswing since the first one was developed in 1997 (there are currently over 150 mental health courts nationally), there has been little research regarding their outcomes. In the 2006 Brooklyn Mental Health Court evaluation, participants demonstrated considerable improvements in areas of functioning, suggesting that additional research with a comparison group would find that involvement in this court positively impacts these outcomes.

Program highlight: Bronx Mental Health Court

The Bronx Mental Health Court began formal operations in January 2001 and serves approximately 225 participants on any given day. Individuals with violent or non-violent felony charges and "serious and persistent" mental illnesses are eligible for participation, while misdemeanor defendants are considered on a case-by-case basis. More than 50 percent of participants have a major affective disorder (i.e., Bipolar Disorder, Major Depressive Disorder) and more than 33 percent present with psychotic symptoms upon admission to the program. The Bronx Mental Health Court is a post-plea court where participants plead guilty and have their sentences suspended for the duration of their treatment plan. Upon completion of the program, participants are able to plead to a lesser charge. The Bronx Mental Health Court, which serves large

Notes

Hispanic/Latino and African-American communities, emphasizes cultural competence. In 2006, The Bureau of Justice Assistance (BJA) designated the Bronx Felony Mental Health Court as one of five mental health courts in the USA that are learning sites to provide a peer support network for local and state officials interested in planning or improving a mental health court.

**NYS mental health courts**

The New York State Unified Court System’s Office of Court Administration (OCA) and the Center for Court Innovation (CCI) oversee and support mental health courts and other court-based alternative initiatives across the state. OCA partners with other state agencies, as well as local criminal justice and human services organizations, in the development of new mental health courts as well as the continued operation of existing courts as an ATI. Since 2006, OMH has provided funding for statewide training for mental health courts, as well as ongoing funding in support of the Brooklyn Mental Health Court. Since 2001, DPCA has funded the Treatment Alternatives for a Safer Community (TASC) team for the Bronx Felony Mental Health Court; last year, an additional contract was awarded to expand the program to the Queens Mental Health Court.

The Mental Health Court Connections (MHCC) program is designed to support counties that do not currently have a mental health court, but are interested in providing their communities with a meaningful response to the problems posed by defendants with mental illnesses in the criminal justice system. MHCC provides judges with the resources necessary to consider effective ATI dispositions for those defendants whose mental illness contributed to their current criminal justice involvement and whose participation in MHCC will not create an increased risk to public safety. Three counties in NYS currently have a MHCC program: Albany County, Dutchess County and Rensselaer County.

OCA has identified eight additional jurisdictions that plan to develop either a mental health court or Mental Health Court Connection in 2008. These jurisdictions participated in the jointly sponsored OCA/OMH annual training session on May 5th and 6th in Syracuse, NY to begin the implementation process.
### Operational mental health courts in NYS

1. Brooklyn Mental Health Court
2. Bronx Felony Mental Health Court
3. Bronx Misdemeanor Mental Health Court
4. Queens Mental Health Court
5. Queens Misdemeanor Mental Health Court
6. Westchester Mental Health Court
7. Suffolk Mental Health Court
8. Buffalo Mental Health Court
9. Rochester Mental Health Court
10. Niagara Mental Health Court
11. Plattsburgh Mental Health Court
12. Lackawanna Mental Health Court
13. Utica Mental Health Court
14. Jamestown Mental Health Court
15. Montgomery Mental Health Court
16. Lockport Mental Health Court
17. Nassau Mental Health Court

### Jurisdictions planning new mental health court or MHCC

1. Schenectady County Mental Health Court
2. Auburn City Mental Health Court
3. Olean City Mental Health Court
4. Dunkirk City Mental Health Court
5. Middletown City Mental Health Court
6. Putnam County Mental Health Court
7. White Plains City Mental Health Court
8. Sullivan County Mental Health Court
APPENDIX E: Guidelines for mental health clinic standards of care and sequential screening of risk for violence

Mental health clinic standards of care: interpretive guidelines

Clinical standards of care are essential for access to and quality of care for persons served by licensed clinics that provide mental health services. Such standards of care must be incorporated into the policies of these licensed clinics and be applied consistently throughout the State.

We provide the following description of clinical standards for adult outpatient licensed clinics at this time as a result of recent reviews of care that revealed that too often these standards, which we believe to be fundamental to good care and a longstanding expectation of clinic services, may not be explicitly understood, regularly considered or consistently met. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements.

I. Client care

A. Evaluation

By the time the client arrives for initial evaluation, a single clinician should be designated as responsible for ensuring that a comprehensive evaluation is completed in a timely manner. With the client’s permission, the clinician should pursue information from other available sources, particularly family members, significant others and current and past providers of services. The evaluation should include:

- A thorough exploration of current concerns, goals and symptoms
- A review of mental health history including past successes and difficulties, prior interaction with mental health care professionals and past treatments, including medications, adherence and preferences
- Current or past use, abuse or dependence on alcohol or other substances
A thorough understanding of the client's social circumstances, support network, and ongoing life-stressors, including family issues, housing stability and past traumas
- An initial risk assessment, including risk to self and others
- Medical history and treatments

B. Care plan

Every client is required to have a comprehensive care plan, developed in a timely manner and signed by all clinicians participating in the person's care and by the supervising psychiatrist. The care plan should be:
- Recovery oriented, including a focus on work and/or education
- Responsive to the client and family cultural and linguistic needs
- Person centered in that the goals are developed with the recipient of service and fashioned to meet the aims and preferences of the client
- Updated according to the client's needs and regulatory requirements

C. Ongoing care

1. Attending to the Consumer and Family
   Consistent with the mission of a clinic is the need to be available and accountable to its clients and their families. This includes flexibility in time and place of appointments, after-hours responsiveness and shared decision making. A clinic may directly provide care, make referrals and collaborate with other providers, including the client's primary care physician.

2. A Primary clinician
   A primary clinician should be identified for each clinic client in a timely manner.

3. Patient safety and security
   The primary clinician should ensure that appropriate and ongoing safety assessments are completed. These would include assessments of risk to self and others as well as making contact with other providers, community agencies and supports, family members and significant others, and past treatment providers when appropriate.

4. Engagement and retention in care
   A primary goal for clinic services is client engagement and retention in care in order to assist the person in achieving his or her goals. The frequency and nature of client contacts with members of the treatment team should be commensurate with the severity of problems and the prescribed treatment plan. Diagnosis and treatment of a co-occurring substance use disorder, when present, is a best practice and will enable clients to remain in care (See Appendix on Co-Occurring Disorders). The identified primary clinician
should be responsible for ensuring that the appropriate level of engagement is occurring at all times.

5. Attention to co-occurring disorders
Clients in mental health clinics commonly show the presence of a co-occurring medical and/or substance use disorder (including alcohol, drugs and tobacco). The treatment of a co-occurring disorder, whether in the mental health clinic, in a chemical dependency program or in primary medical care, is essential to consumer wellbeing and recovery and should be a primary clinical administrative goal for the clinic.

6. Communication with families
Families or significant others should be contacted as soon as possible, with proper consent, when an individual is beginning treatment, and should subsequently be involved as partners in the development and implementation of the plan of care; families or significant others should also have all information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis.

7. Disengagement from treatment
When clients refuse or discontinue participation in all or part of the agreed-upon care plan, all members of the treatment team as well as collaborating providers and agencies should be made aware, especially the treating psychiatrist and/or clinical supervisor, and should conduct a review of the client's history, previous assessments of risk to self or others and render an opinion as to any aggravating or mitigating factors related to risk, with the clinician taking appropriate actions for the timely re-engagement of the client, including assertive outreach commensurate with the degree of assessed risk.

II. Clinical administration

A. Caseloads
The clinic supervisor or director should be responsible for ensuring that complex, time-intensive cases are evenly distributed and considered for more experienced clinicians, and that the number of assigned clients permits the appropriate delivery of services.
B. Supervision

Clinic leadership should provide regular guidance and oversight for staff (especially new staff), with attention to ongoing care as well as emerging client problems or crises.

C. Integration and information sharing

When clients receive services from more than one clinic or agency, efforts will be made to ensure that all involved treatment providers have a shared understanding of the client’s goals and progress, and that the respective intervention plans are integrated, complementary and reflected in the client’s records. Current State law allows clinicians from OMH-licensed or operated facilities or providers under contract with OMH or DOHMH to speak specifically about the care of a client they are treating as a best practice and when clinical circumstances warrant, and without consent of the client. Furthermore, current state law also permits these mental health providers to share relevant clinical information, without consent, when a client is referred for services to another mental health provider of a facility that is licensed, operated or contracted by OMH or DOHMH.

D. Communication

Complex care requires that case managers and clinicians from multiple disciplines provide concurrent services, within one agency or among multiple agencies. It is imperative that these individuals have ready access to one another and share appropriate information at regular intervals, when there is evidence of emerging instability and during periods of crisis.

Guidelines for sequential screening of risk for violence

Safety, both of individual clients and of the public, is a fundamental aspect of psychiatric treatment. Accordingly, the assessment and management of the risk for violence is an essential component of clinical care. For most clients, it can quickly be established that the risk of violence is low and, in the absence of a possible change in their level of risk, additional assessment is not needed. However, when indications of elevated risk are present, more detailed assessment is required. The process of risk assessment involves the identification of risk factors present, followed by an assessment of the significance of each factor and consideration of how these factors together indicate a certain level of risk.
The following stepwise evaluation is recommended:
.Utilities Universal violence risk screening for all clients as part of the intake process,
.Utilities Targeted violence risk assessment when screening indicates increased risk,
.Utilities Violence risk-focused treatment when indicated, and
.Utilities Reassessment when the client's clinical, legal or contextual status changes.

Although the emphasis of this appendix is on the assessment of the potential for violence by individuals under psychiatric care, it is important to note that notwithstanding public perceptions of the dangerousness of persons with mental illnesses-they are actually more likely to be the victims of violent crime than the perpetrators. The relationship between violence and mental illness is complex and strongly correlated with additional variables besides the presence of mental illness alone, such as a history of prior violence or the influence of co-occurring substance use.

I. Risk assessment framework

A. Universal risk screening

The routine evaluation of all new clients requires the assessment of risk. All clients should be asked directly whether they have ever fought with or hurt another person and whether they have recently thought about hurting another person. In addition, there are critical events (e.g. past hospitalizations and arrests) that raise the possibility of past violence. As with any clinical assessment, some information may be provided directly by the client. Whenever possible, collateral sources should be included in the assessment process for additional information or corroboration. Collateral sources include family members, friends, or other significant close contacts and sources of support, as well as prior treatment records.

Recommended areas for screening include determining if there is any history of:
.Utilities Physical or sexual aggression towards other people
.Utilities Deliberate self-injury
.Utilities Emergency room visits or hospitalization related to threatening or violent behavior
.Utilities Arrest or orders of protection related to the client's threatening or violent behavior
.Utilities Current or recent thoughts or behaviors that others have interpreted as threatening

Additional screening areas, in cases where a higher index of suspicion is warranted regarding a predisposition to aggression, include a history of:
.Utilities Problems with controlling anger
.Utilities Expulsion from school related to violent behavior
.Utilities Workplace or domestic violence
B. Targeted risk assessment of clients with histories of violence or recent ideation

Should screening yield a history of violent behavior or recent ideation, a more in-depth analysis of the risk of future violence is derived by obtaining the details of violent behavior or ideation and by identifying factors that increase the level of a client’s acuity or protective factors that mitigate risk.

Ultimately, clinical judgment is necessary in assessing how various symptoms and factors are related to violent behavior. A thorough review of the following areas can be used to guide clinical judgment:

◆ Details regarding the history of violence or violent ideation, including severity, context, and use of weapons.
  Presence of factors associated with incidents of aggression including:
 ◆ Interpersonal conflict, unstable relationships, poor social support
 ◆ Employment or financial problems
 ◆ Substance use, whether due to active intoxication, withdrawal, or craving
 ◆ Psychiatric conditions or active symptoms, including those related to personality disorder
 ◆ Treatment noncompliance or lack of insight
 ◆ Criminal behavior
 ◆ Ongoing access to weapons

◆ If there is a history of violent ideation, but not violence per se, is/are there:
 ◆ A plan and available means for acting on the ideation
 ◆ Steps taken in furtherance of the plan
 ◆ Factors that inhibited acting on the ideation

◆ Presence of protective factors, including:
 ◆ Outside monitoring (court, AOT)
 ◆ Mental health outreach teams (e.g., ACT teams)
 ◆ Treatment efficacy and compliance
 ◆ Stable social support, work, and/or housing

Application of assessment findings to risk-focused treatment

It is not necessarily the total number of risk factors present that indicates a heightened risk. A single, severe factor may in and of itself indicate substantial risk concerns. Similarly, protective factors may significantly mitigate risk. After factors have been identified as related to past violence, consideration must be given to how relevant these factors remain in the present or foreseeable future. Risk assessment assists in the characterization of acuity and identification of areas of need; when risk has been identified, actions to address that risk must be reflected in the initial treatment plan.
Ongoing treatment plans should:
- Reflect interventions taken to manage identified risk factors
- Include efforts to actively engage the client and involve available supports
- Take into account prior treatment successes and failures
- Monitor the improvement or worsening of significant risk factors to guide
  any necessary change in management

When a client already in treatment misses an appointment or drops out of treatment, a review
of the violence risk assessment may help guide the clinician’s response. A client with active
symptoms, a history of violence, and numerous risk factors for violence requires a greater
degree of outreach and engagement. It must be emphasized that no guideline can include every
possibility; therefore treatment decisions remain in the domain of clinical judgment, as applied
on an individual basis to each particular combination of circumstances and needs. Potential
multidisciplinary interventions include:
- Identification and monitoring of warning signs indicative of imminent or increasing risk
- Evaluation of medication regimen and consideration of additional treatment modalities
- Involvement of family, social services, case management, or other supports
- Consideration of social stressors
- Increased monitoring, including increased frequency of clinical contact
  or consideration of AOT
- Increased level of care, including hospitalization

D. Reassessment

There are specific junctures in treatment when reassessment of violence risk, following the
framework described above, should take place. If a client becomes more symptomatic, or if
treatment appears to be failing, reassessment should occur. When considering a client for hospi-
tal discharge, an assessment of risk factors for violence and whether risk factors for aggression
have been addressed adequately is necessary. Similarly, prior to other changes in client status
such as changes in level of hospital restriction or confinement, termination of clinic care, or
discontinuation of an AOT order, reassessment of violence risk is indicated.

With any framework for assessment, there remains the possibility that clinicians may encounter
cases where the level of risk remains unclear, or where the management of identified risk fac-
tors is complex and difficult. In such cases, adequate supervision and/or consultation for assis-
tance with either further assessment or management recommendations is indicated.
II. Actuarial tools

The methods by which violence risk is assessed have been classified as either clinical or actuarial. Despite improved accuracy over unstructured clinical risk assessment, actuarial tools have important limitations. Past violence is the most significant factor in predicting future violence; actuarial tools will often not identify the risk of individuals who have yet to engage in serious violence. Also, actuarial tools are typically developed on a specific target population; the general clinic population is sufficiently diverse that there is no one particular actuarial tool that has been validated for use with a general clinic population.

The importance of proper training in the use and limitations of any given actuarial tool prior to implementation must be emphasized. These tools should not be approached as simple rating scales. Without an adequate understanding of their application, actuarial tools have the potential to misguide the estimation of risk.

Rather than adding any one particular actuarial tool as a required component in the standard of care for risk assessment in the general client population at this time, we recommend the sequential screening of risk for violence outlined here. However, depending on the specific circumstances, actuarial tools, administered by clinicians versed in their administration and interpretation can enhance the accuracy of the risk assessment.
Safety, Fairness, Stability: Repositioning Juvenile Justice and Child Welfare to Engage Families and Communities

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Cover Art:

Family relationships are among the most important relationships youth have. By maintaining youths' family roots, their bond to their homes and their communities, the juvenile justice and child protection systems can help provide youth and their families with a sense of well-being, safety and fairness. The cover art represents a sort of family branch, where all of a youth's positive relationships influence the path of their life, providing stability and support. The more family, communities, agency leaders, judges or lawyers get involved, the stronger the branch becomes.
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May 2011

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Foreword

There is no other relationship with greater significance in our lives than those we have with our families—whether they are our birth or chosen families. They should serve as the anchor in our lives, as the lifeline to everything else we accomplish. As noted by the authors of this paper, Joan Pennell, Carol Shapiro, and Carol Spigner, “for youths to grow into responsible and productive adults, they need a foundation of safety, fairness, and stability.” Further noting that “this foundation is especially weakened for youths involved with both child protection and juvenile justice,” they make the case for devoting our efforts to maintaining youths’ connections to their homes, schools, and communities in an appropriate manner, and by doing so give youth who are too often alienated from their families and our mainstream society “a sense of belonging, competence, well-being, and purpose.” It is this sense of belonging that many youth involved with child welfare and juvenile justice lose as they and their families experience these systems.

This paper provides a pathway to improving these systems in a manner that will leave children, youth, and families with a different set of experiences. But this pathway requires those working within those systems—as agency leaders, supervisors, line staff, or judges and lawyers—to adopt a new lens in viewing their work in engaging families. Socrates once said, “I can not teach anybody anything. I can only make them think.” That is the challenge undertaken by the authors, and I commend them for tackling this challenge not only with one system of care, but by asking readers to understand the challenge across systems—and to think differently about how we work with families that are frequently experiencing multiple systems at the same time.

It is my hope, therefore, that this paper makes you think about how you can look at family engagement in a different light, build upon your work to date, and make progress in improving how you work with the families with whom you come in contact, whether it be in the field of juvenile justice, child welfare, behavioral health, or education. I believe the authors of Safety, Fairness, Stability: Repositioning Juvenile Justice and Child Welfare to Engage Families and Communities paint a hopeful picture of our readiness to do so, to move to the next level of work—of practice and policy—within and across these systems.

My hopefulness is supported by the fact that there is a different kind of field building underway in this country—it is no longer just the child welfare field, the juvenile justice field, the behavioral health field, or the education field. These fields are doing their work—viewing their work—in a different way: across systems. This change in perspective is essential, and the work being undertaken across systems to achieve better outcomes reveals a very specific effort to work more effectively to create stronger connections for the children and youth in those systems—pro-social connections that will support them in their path to adulthood.

I hear a lot about “connections” in the dialogue about our work with children and youth. I interpret this to mean “connections” that lead to, or help restore, significant family relationships that provide safety, fairness, and stability in a meaningful way. That is what the workforce in child welfare, juvenile justice, behavioral health, and education do as a key part of their work—provide these connections. In many instances, this means creating a stronger connection to pro-social peers and adults outside of the family domain; in others, it means supporting families in their efforts to better nurture their youth. This includes providing a sense of safety, improving well-being, and creating permanence in their lives. I share these thoughts as part of this foreword because the lessons learned in my career are that if we get this very basic and fundamental element right, we will have a better chance of succeeding in our work to improve the life outcomes for the children and youth with whom we come in contact in our work.

So how do we move forward in advancing this work and bringing this perspective to life? What are the implications for our policies and practices? On a policy and practice
level, in order to do this work well, our focus must be on children, youth, and families within the context of the communities in which they live. We have to understand and then act upon the notion that the families and communities from which the children in our care come are not our enemy territory. And when we “wrap” services, support, and supervision around each child and family in an individualized way, these efforts must be based in the community and backed by strong community connections. It is in this way that we make positive, long-term connections for children and youth and create a sense of stability in their lives.

As suggested by the authors, to do this we must develop strong local, state, and national policies that address what we want every child and youth to have as the developmental underpinnings of their growth into adulthood—policies that encompass elements related to child welfare, juvenile justice, behavioral health, and education, but that are family focused. We must embrace the idea that whether it is children and youth in our child welfare or juvenile justice systems, their families have both strengths and weaknesses, and in working with them we need to identify and build on those strengths and help them to overcome their weaknesses.

Further, we need to disabuse ourselves of the notion that we can or should separate these youths from their families. Whether it be a youth receiving services while remaining in the home, reentering the community from placement in the juvenile justice system, reuniting with family members after being removed from their care and custody due to abuse or neglect, or aging out of foster care or the juvenile justice system (or both), we need to work with our young people as they reengage with their families, helping them to navigate those families in a healthy way.

This push and pull around the role of families has been a focal point of the juvenile court since its inception 110 years ago. We have been conflicted about how to best apply the doctrine of *pars pro patriae*, allowing the system to serve temporarily as the parent, while at the same time working in a respectful and supportive way with the families of the children and youth who have come to our attention—often failing to provide the family-centered and family-driven resources needed to serve the child and family’s best interests. We have struggled, in this regard, with how to view and place the family in our work with their children, and what we know now is that we do our best work if the family is at its core, not the periphery.

This requires us to approach our work in a different manner, ensuring that our efforts reflect the traits of effective practice, those that are captured as the essence of this paper. In order to make this conversion, we must build a strong workforce that embraces the underlying values that support this work. It is a workforce that fully supports involving family as part of the team and demonstrates sensitivity to each child’s race, culture, gender, and sexual orientation—and the need for “connections,” primarily to family. It is a workforce open to adopting new policies and practices that better support the key roles families should play in mapping out their future.

Abraham Maslow once said: “I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.” In the same vein, the authors suggest an array of “tools” that allow us to work with greater precision and effectiveness in achieving greater safety, well-being, and permanence as our primary goals.

This is difficult work. It is about building bridges between workers and the families they serve; between the child welfare, juvenile justice, behavioral health, and education systems and communities, and between systems. Peter Block, a leading thinker and author on organizational change and collaboration, addresses what it takes to work in a collaborative manner. He discusses the need to share power, turf, and control; to share resources; to be transparent; to tell the truth—the truth about what we do well and what we don’t do well; to trust one another; and to engage in acts of surrender. This is difficult to do, particularly in difficult financial times, when our tendency is to protect what is ours. But these traits must be shown in not only how the workforce in these systems engage each other, but in part how they engage the families they serve: being transparent, telling the truth, and building trust.

Therefore, we need to create a shared vision, in part by identifying the strengths and weaknesses of our service systems and by developing greater levels of cooperation.

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between the child welfare, juvenile justice, and related systems of care. We need to create an environment of trust that leads to risk taking without the threat of blame.

Indeed, it will take all of these things for us to be successful in better engaging families and the youth to whom they are connected. As the authors and commentators so powerfully convey, we cannot be successful in reconnecting our children and youth to their families and communities unless we think about this work differently, through the lens of the family and from a truly family-centered perspective. I thank both the authors and commentators for exploring this issue in such a meaningful way and helping us to understand how we can better engage families within and across systems and achieve better outcomes for the children, youth, and families we serve.

Shay Bilchik
Research Professor and Center Director
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I. Introduction and Background

For youths to grow into responsible and productive adults, they need a foundation of safety, fairness, and stability. This foundation, however, is especially weakened for youths involved with both child protection and juvenile justice. These youths have experienced the maltreatment and resulting trauma that eats away at safety. Their cultural and economic backgrounds along with defiant attitudes can jeopardize their social, educational, and legal rights and undermine a sense of fairness, only escalating oppositional behaviors. Their histories of maltreatment and offending often lead to their removal from their homes, schools, and communities. These separations can further erode the connections that give youth a sense of belonging, competence, well-being, and purpose.

Youths involved with both child welfare and juvenile justice need:

- **Safety** — protection from maltreatment and resulting trauma
- **Fairness** — respect for rights and cultural diversity
- **Stability** — sustained familial and community connections

A strategy for strengthening these crucial connections, and more broadly providing greater safety, fairness, and stability, is for child welfare, juvenile justice, mental and behavioral health, schools, and other involved systems to work together in engaging youths and their families in decision making and planning. This strategy, called family engagement, has been defined as any role or activity that enables families to have direct and meaningful input into and influence on systems, policies, programs, or practices affecting services for children and families (New York State Council on Children and Families, 2008). In this context, the family needs to be broadly defined to encompass those whom youths see as their family group, whether based on biological, social, foster, or adoptive ties. Many youths turn to their familial connections on leaving care or custody, and joint planning can help in making these transitions successful (Collins, Spencer, and Ward, 2010; Ryan and Yang, 2005). This collaborative approach needs to take place with youths and families about their particular situations and more generally about agency programming and public policy (Briggs and McBeath, 2010; Luckenbill and Yeager, 2009). This multilevel engagement will help involved systems figure out how best to serve youths as well as members of their families, schools, and communities.

Family groups are those whom youths see as their lasting connections, those to whom they turn over the long term.

Child welfare and juvenile justice have much to offer in helping young people and their families, and by acting together, the two systems can remove false dichotomies between upholding the best interests of the child and those of the greater society. Nevertheless, for youths who cross over between child welfare and juvenile justice, family engagement presents complex challenges. First, the services of these two systems are usually mandatory rather than voluntary, sometimes involving removal of the youth from the home for the safety of the youth or the public, and as a result, can generate tensions between the agencies and the families with whom they work. Second, in making decisions, practitioners often confl ate race, risk, and poverty; this produces disparities in treatment for children and youth of color living in poverty and heightens tensions between their families and public agencies (Baumann et al., 2011). Third, child welfare and juvenile justice are too often operating at cross purposes because of differences in mandates, cultures, and organizational structures, making it difficult for youths to navigate the transition into adulthood (Attschuler et al., 2009). The lack of collaboration adversely affects youths' schooling and access to mental health services (Leone and Weinberg, 2010). In other words, conflicting purposes lead to competing directives to youths and their families.
For crossover youth—those involved with both child welfare and juvenile justice—family engagement is complicated. These systems deliver involuntary services, often with the greatest impact in communities of color. The two agencies have different mandates and often send competing directives to youths and their families.

A fourth complexity is the expansion of the number of parties who need to be involved when addressing both youth protection and youth offending. If the focus is on a protection plan, then child welfare should invite the participation of the youths, their families, and other relevant services. If instead the focus is on the offense, then juvenile justice should involve the youths, their families, relevant services, and the victims along with their supports (MacRae and Zehr, 2004). The victims of crime may come from within the family, schools, online forums, and community; their participation clarifies the impact of offending. For crossover cases, further decisions need to be made about which agency convenes the meeting, who takes part in the deliberation on offending versus protective issues, and who authorizes the plan and its resourcing.

For crossover youth, two streams of practice theory can inform how to engage families. These are system of care (Strolin and Friedman, 1986) and restorative justice (Zehr, 1990). System of care emphasizes wrapping services around youths and their families in a manner that they see as empowering them to act on their needs and aspirations. Because family groups are invested in their young relatives, family members work to get youths back on track emotionally, behaviorally, and spiritually while keeping them in their homes and communities. A family group approach extends a system of care beyond formal services to include informal supports, and this combination of formal and informal networks is best referred to as systems of care. Restorative justice emphasizes helping youths make amends for their wrongdoing, renewing the relationship between youths and those they have harmed, and addressing the underlying causes of the problem behaviors. Combining systems of care and restorative justice advances the leadership of youths, their families, and others affected by the wrongdoing in decision making while maintaining supports, protections, and limits firmly around youths.

Family engagement promotes both systems of care, which wraps services around youths and their families, and restorative justice, which addresses the youths’ wrongdoing and renews relationships.

Integrating system of care and restorative justice approaches has the potential to reposition juvenile justice and child welfare so that they collaboratively engage youths, families, victims, and others in the community in advancing safety, fairness, and stability. In explicating how such engagement works, the three authors of this paper bring a depth of understanding based on their long-term involvement in child welfare and juvenile justice reform, their research and scholarship, and their commitment to social and cultural equity. This paper is based on the premise that system change is necessary and feasible.

The authors assume that positive system change results from engaging youths and their families and communities, including the victims of crime, in setting goals, making action plans, and collaborating on efforts.

To be effective, the leadership of the youth and family participants needs to be evident in making case decisions as well as in shaping agency programming and public policy. Such multilevel engagement repositions power relationships by tapping into the strengths of all participants, developing a sense of individual and collective efficacy, and promoting trust among groups with lengthy histories of suspicion and anger toward each other. Such repositioning is especially needed because it is all too common for both the juvenile justice and child welfare systems to have strained relationships not only with the youths and their families and communities but also with other child-serving agencies. Given this aim of repositioning relationships, the authors’ primary focus is on mechanisms for inclusive and culturally respectful decision making and enactment of these decisions, rather than on changing youths through therapy or correctional measures.
Crossover Youth: Need for Intervention

Safety, fairness, and stability are in short supply for youths who come from struggling families in impoverished communities. Children from these families are at risk of child maltreatment, which often becomes the precursor to antisocial behaviors (Maughan and Moore, 2010). These youths are more likely to start offending as children, to run away from home, to leave school early, to use drugs and alcohol, and to associate with problematic peers. Unless the underlying causes of their offending are addressed, they are on a trajectory to commit serious and violent juvenile offenses and to continue criminal activity well into adulthood (Farrington and Loeber, 2002; Moffitt, 2007; Vazsonyi, Trejos-Castillo, and Huang, 2007).

These troubled youths show up on the caseloads of child welfare, juvenile justice, or both systems as well as on those of other child-serving agencies. They are the crossover cases between child welfare and juvenile justice. Some may be involved with both systems at the same time, and of those, a smaller group is dually adjudicated by the courts. The extent of the overlap is difficult to gauge because the United States lacks a national database that links cases from child welfare and juvenile justice. Studies have suggested that between 9 and 29 percent of children involved with the child welfare system later engage in delinquent activities (Herz, 2010). Though we do not have a firm grasp of the number of children who flow from the child welfare system to the juvenile justice system, we can say that the phenomenon reflects, in part, an inadequacy of the child welfare system in its capacity to assist families in resolving the issues that brought children into care. In addition, significant numbers of youth age out of the child welfare system each year without being anchored to family and/or significant relationships (U.S. Department of Health and Human Services, 2010; Pecora et al., 2005). These young adults are at risk of homelessness, incarceration, unemployment, and depression (Courtney et al., 2009).

Heavy reliance by both systems on foster care, group homes, congregate care facilities, and secure custody disrupts a young person’s family connections and
schooling and can lead to identification with antisocial and/or delinquent peers and to behavioral, cognitive, and mental health problems. Moreover, incarceration of youths in correctional facilities is likely to inculcate criminal norms, forge gang affiliations, and discourage youths from taking responsibility for their actions (Calhoun and Pelech, 2010). All of this is to the detriment of the safety of both young people and the public (Walgrave, 2008).

Heavy reliance by both systems on foster care, group homes, congregate care facilities, and secure custody disrupts the young person’s family connections and schooling and can lead to identification with antisocial and/or delinquent peers.

Disproportionate Minority Contact: Why Change Is Imperative

In the United States, youths of color are more likely than their White counterparts to be charged and incarcerated (Muncie, 2009). Substitute care elevates these disparities for minority groups. It is well documented that, compared to White children, African American and Native American children are more likely to be removed from their homes by child welfare and to be retained longer in care. The same is true for Latino children in some states (Belanger, Green, and Bullard, 2008; Texas Department of Family and Protective Services, 2010). If these placements destabilize and children experience multiple placements, the likelihood of juvenile justice involvement increases, especially for African American and Latino youths (Barth et al., 2010; Ryan et al., 2007).

Furthermore, dually involved youths are less likely to be put on probation and more likely to be ordered into a group or correctional setting, with detention a more likely outcome for minority youths (Ryan et al., 2007). Congregate care is an expensive option, often physically far from youths’ families, which, in turn, increases the psychological distance between youths and their families (Barth and Chintapalli, 2009). Moreover, group homes are associated with greater placement instability, increased use of psychotropic medications, academic problems, and further offending (Ryan et al., 2008). Juvenile justice involvement has been an avenue for providing needed services to youths experiencing mental health crises; however, the programs available cannot meet the volume of demand and may be ineffective due to their culturally insensitive approach to African American youths (Briggs and McBeath, 2010).

Displacement for young people, especially those of color, is compounded by the exceptionally high rates of incarceration of one or both of their parents. Almost 2.5 million children have at least one parent incarcerated, depriving them of potential economic support even after the parent is released, since “ex-cons” are often unemployable (Garland, 2001, p. 103). Of the more than 2.2 million adults incarcerated, 62 percent of female prisoners and 51 percent of male prisoners have children under the age of 18 (Sabol and Couture, 2008). Forty percent of incarcerated fathers are African American (Sabol and Couture, 2008). This trend is moving upward: Between 1991 and 2007, the number of children of incarcerated parents increased 80 percent (Glaze and Maruschak, 2008). Fifty percent of these children are under the age of ten, while 32 percent are between the ages of ten and fourteen (Glaze and Maruschak, 2008).

The impact of the criminal justice system goes beyond jail and prison. When probation and parole supervision are added to the equation, more than 7 million children are affected (Drucker, 2006).

This background and summary of the research on child welfare and juvenile justice policy and practice as they relate to family engagement make it clear that change is needed. However, to effectively plan our path forward, it is important to understand the historical context of how these systems have engaged—or not engaged—families over time and how current trends can support a fundamental shift in how we work with the families of system-involved youth.
II. Shifting Views of Parents and Youth: Historical Development and Opportunity for Change

Understanding the history of the child welfare and juvenile justice systems as it relates to family engagement will help to identify both the values and the major tensions that are embedded in current operations. The main underlying values related to this topic concern the rights and responsibilities that children and families possess and the role the state should play when these responsibilities are not met. The history of how both the child welfare and juvenile justice systems engage—or do not engage—families is intertwined with how the systems view these rights and responsibilities and the role of the state in enforcing them. Therefore, this section begins with an overview of the evolution of how the rights and responsibilities of youth and families have been perceived and uses that framework to discuss the historical evolution of how systems have viewed—or not viewed—families as partners in serving youth in their care.

Built upon the framework of human rights, the CRC acknowledges children’s need for special protection because of their immaturity, the primacy of families in caring for children, and the responsibility of governments to enact policies that promote the advancement of children’s rights. It recognizes circumstances that require a child to be removed from the home and explicitly establishes rights to judicial determination of the child’s best interest, ongoing parental contact, and suitable alternative care (Articles 9 and 20) (United Nations, 1989). The CRC also acknowledges that children’s capacities increase over time and that as they mature, they should increasingly exercise their rights to express their views, including in administrative and court hearings. For young people who have committed offenses, the CRC requires legal and judicial safeguards (Article 40) and humane treatment (Article 37).

Although the United States has not ratified the CRC, the government has moved closer to its terms and has ratified some CRC Optional Protocols (Campaign for the U.S. Ratification of the Convention on the Rights of the Child, 2008). Consistent with the United Nations’ Convention, American law views children as immature persons who are developing and cannot speak for themselves. As such, they need the protection of a guardian. Parents are viewed as the natural guardians of their children. The rights of children are not specifically addressed in the U.S. Constitution or the Bill of Rights, but children’s rights have been based in common law, state laws, case law, and social policies. Under the family law codes of the states, children and their parents by birth or adoption are legally bound to a relationship of reciprocal rights and responsibilities. The relationship is protected by law, and parents are given broad authority to make decisions on behalf of their children and raise them according to their own wishes. Within this context, children have the right to the support of their parents for food, shelter, clothing, and medical care. Children have the right to an

Rights of Youth and Families

The legal and policy framework that provides rights to children and their families has evolved over time. Children have moved from a position of property within their families to become individuals who have rights and who deserve to be protected from exploitation and abuse. Discussions of the relationship among children, adolescents, the family, and the state have occurred both within countries and in the global community. The most noteworthy example of the global discussion occurred in 1989 when the United Nations General Assembly enacted the Convention on the Rights of the Child (CRC).

Children have moved from a position of property within their families to become individuals who have rights and who deserve to be protected from exploitation and abuse.
education that allows them to reach their potential and have the right to be protected from abuse, neglect, and exploitation. Additionally, social policies related to child labor, compulsory education, protective services, and child health have further defined the rights of children.

Parents as natural guardians have the right to custody and control of their children. They can make major decisions for their children, including giving consent for minors to receive medical treatment, get married, and enlist in the military. Parents have the right and duty to protect, train, and discipline their children. With these rights come the responsibilities to support their children and provide food, shelter, medical care, and education (U.S. Department of Health, Education, and Welfare, 1961; American Bar Association, 2004).

The state has an interest in the well-being of children and in the development of individuals who can contribute to the civic and economic health of the society. As such, the state has the right to intervene in the life of a family when children are found to be in jeopardy and in need of protection due to maltreatment or delinquent behavior. Acting as *pares patriae*, or “parent of the country,” the state can conduct investigations, initiate legal actions in juvenile or family court, and remove children from their parents. In these circumstances, the state has an obligation to make decisions guided by the best interest of the child.

Given this context of the rights of parents, families of dependent and delinquent children have historically been viewed as neglecting their responsibilities and therefore being a contributing factor to their child’s dependency or delinquency status. Indeed, as the next section will explore, families have historically not been engaged as partners in their child’s child welfare or delinquency cases. However, practitioners and policymakers are increasingly seeing the value of engaging families. Although the framework of children’s and parent’s rights has been used to vilify parents and disconnect them from their children, the framework has also supported a historical shift to the current focus on family engagement in effectively serving youth in the child welfare and juvenile justice systems.

Implicit in our understanding of the rights of children and the rights and responsibilities of parents is recognition of the psychological importance of the parent-child relationship to the child or adolescent’s development. Our society has an obligation to protect and rehabilitate children and teens in the context of their families, whenever safely possible. But the child welfare and juvenile justice systems have not been able to sufficiently institutionalize family engagement strategies in order to best use the power of these relationships to bring about changes in families, communities, and child-serving systems. To better understand why this has not occurred, and how we can better support family engagement moving forward, the next section presents an overview of how the child welfare and juvenile justice systems have historically viewed and engaged families in their work.

**History of Family Engagement in Juvenile Justice and Child Welfare**

Current responses to maltreated and delinquent children and youth are built upon a historical foundation that viewed parents as absent, inconsequential, and/or detrimental to the well-being of their children. Based on this premise, children were placed in institutions or removed and sent to alternative families long distances from their original communities (Axinn and Stern, 2008; Rothman, 2002). To the extent that the children came from distinct racial, ethnic, and cultural communities (such as Native American tribes, European immigrant groups, or descendants of Africans), their communities were also disparaged and seen as contributing to the children’s problems.

Although child welfare and juvenile justice systems have the same origins, they have diverged in their development because of differences in goals, functions, and areas of controversy. The antecedents to the current approach to child and youth services are the practices that developed to care for dependent and delinquent children early in the history of this country. These children were often orphans who had lost their parents to death by disease, war, or abandonment. Because the emerging communities of the colonial era needed all available labor, they took action to limit or reduce dependency. Therefore, children in need were provided with care and given the opportunity to
learn a skill through either apprenticeship orindenture. Those not able to work and deemed “worthy” (such as widows and their children, the disabled, and the elderly) received cash relief from public authorities and/or charities (Bremner, 1974; Axinn and Stern, 2008; Myers, 2008; Abramowitx, 1988).

Although child welfare and juvenile justice systems have the same origins, they have diverged in their development because of differences in goals, functions, and areas of controversy.

As the nation developed and wealth was acquired, specialized institutions—including orphanages for children and houses of refuge for youth who broke the law—were created, and a system of service through philanthropy was established. These facilities for children and youth were built by religious organizations and philanthropists as well as by local governments. The focus was on the care and training of youth, and the facilities operated on a rigid schedule to foster discipline. Due process rights were not afforded to delinquent youths or their parents, and juveniles were often malnourished or forced to do hard labor at the houses of refuge (Shoemaker, 2009).

For youths who were not orphaned and whose parents were alive, little attention was paid to the parents, who were viewed as contributors to the delinquency and dependency of their children. Within these institutions, there was general distrust for the competence of parents who were poor—so much so that superintendents of children’s institutions discouraged visits by parents except under extremely restricted conditions. Separating children from the bad influence of their parents became a priority.

Despite these efforts, a troubling number of indigent children lived on the streets of New York City in the early nineteenth century. As a result, in 1855 the Children’s Aid Society was established and soon thereafter began moving indigent children, most of whom came from immigrant families, by train to the Midwest to live with farm families. But not everyone was happy with this approach. A number of children ran away from their foster homes to return to their families, while a number of parents attempted to find their relocated children.

During this period, families, especially poor immigrant families, were commonly viewed as a threat to their children’s development because parents continued to practice the ways of the old country and were believed to be unprepared to help their children participate in American life. In contrast, the Progressive Era brought about community-based efforts to help immigrant families and their children adjust to American culture through the establishment of settlement houses, which taught language and other life skills and established kindergartens and social programs for children and their families.

In 1875, the first Society for the Protection of Cruelty to Children (SPCC) was established in New York City in response to the highly publicized abuse of a youngster by the name of Mary Ellen. Though a voluntary association, the SPCC used an “arm of the law” approach and investigated reports of maltreatment and initiated prosecution of parents who had failed to properly care for their children. The authority of the court was used to punish and fine parents, and when necessary, remove children from their care. Children were placed in institutions or foster homes. The SPCC spread rapidly to the large cities and established a model of investigation and intervention that was later incorporated into child protective services.

It is important to note that the organizations and procedures developed in the nineteenth century did not apply to African American children. African American children did not enter the child welfare system during either the slavery or post-slavery era because their status as property meant they were afforded minimal protections.

Once the juvenile court developed at the turn of the twentieth century, the evolution of the child welfare and juvenile justice systems diverged. However, the two systems continued to share some of the same attitudes toward children and their families.

**Juvenile Justice**

The first juvenile court in the United States was authorized by the Illinois Juvenile Court Act of 1899 and was founded in Chicago. Other states soon followed and created juvenile courts of their own. Rather than seeing children as little adults (as was common throughout the eighteenth and into the nineteenth centuries), pioneers in the new