Juvenile Mental Health Court

Project Abstract

Collin County is the sixth largest county in Texas with a population of citizens (of over a million) and lies just north east of the Dallas-Fort Worth Metroplex. The county has 13 District Courts. The 417th District Court will preside over cases for the Juvenile Mental Health Court (JMHC) which will provides probation and intensive supervision services for deferred and adjudicated juveniles, pre- and post-adjudication detention, rehabilitation services, and alternative education services for expelled juveniles.

The mission of the Collin County Juvenile Mental Health Court Program (JMHC) is to seek to reduce recidivism by connecting defendants experiencing mental illness to supportive services and appropriate treatment as an alternative to incarceration by utilizing a multidisciplinary approach. The program will serve juvenile defendants allowing them to make significant changes in their lives so that they can avoid further involvement with the criminal justice system. The team will effectively address mental health problems by connecting participants and their family's to treatment providers and community resources. JMHC aims to hold participants accountable for their actions while building on their strengths and reconnecting them to healthy peers, family and adult relationships as well as prosocial activities.

The program's purpose will be to serve the needs of youth who are at risk of being removed from their homes due to mental health issues that result in behaviors that make them unmanageable. The program will assess the issues in the home that impact the mental health of the youth and the functionality of the family and work with the family and community resources to address the identified problems and provide the rehabilitative and supportive services that will allow the juvenile to remain in their home with a decreased risk of removal as well as lessened risk of recidivism, thereby keeping the juvenile and community safe.

The Juvenile Mental Health Court Program is a court-centered, outpatient treatment program. The program will be 12 a month grant with intensive follow-up and is open to 20 youth between 12 to17 years of age who have been diagnosed with mental illness. Eligibility criteria for the JMHC will be juveniles diagnosed with the following but not limited to: mood disorder; psychosis; mania; anxiety; anger issues; and ADHD (other mental health diagnosis not listed, will be accepted such as juveniles diagnosed Intellectual and Developmental Disability (IDD)). Also, in order to be eligible into the program, juveniles must meet the following target population. Juveniles must have a DSM-5 diagnosis other than or in addition to substance abuse, ADHD, IDD, autism, pervasive developmental disorder, and an IQ of 70 or greater. Reasons for exclusion include adjudication for a sex crime, severe mental or emotional problems not stable on medication at the time of admission, requiring inpatient mental health care, and youth whom have a history manufacturing and/or distribution of illegal and synthetic drugs (drug dealing).

Problem Statement

Mental illness in the juvenile justice system has become an increasingly obvious problem. The National Center for Mental Health and Juvenile Justice found that 70 percent of youths in the juvenile justice system are afflicted with a mental health disorder, and 27 percent suffer from a disorder so severe it significantly impairs their ability to function (Cocozza and Shufelt, 2010).

In response to the increasing population of defendants with mental illness, the popularity of mental health courts has grown in the last decade (Steadmen and Redlish).

Youth who become involved in the juvenile justice system are more likely than their peers to have been exposed to not just one or two traumatic stressors, but multiple types of traumatic victimization (Abram et al, 2013). These are not just incidents, but types of adverse stressors (e.g., physical abuse, sexual abuse, domestic violence, community violence, life-threatening neglect) that impact youth before they first come to the attention of law enforcement. These youth experience what has been described as "poly-victimization," which is defined as prolonged or multiple exposures to traumatic events (Finkelhor, Ormond, & Turner, 2007). The brain and nervous system are altered by poly-victimization in childhood (Teicher & Samson, 2013) in ways that increase stress reactivity, anger, and impulsivity while reducing the youth's ability to self-regulate. Youth who have been poly-victimized are at high risk for involvement in delinquency and contact with law enforcement and the juvenile justice system (Ford et al., 2010).

A trauma-informed juvenile justice system contributes to restoring order and safety by enabling juvenile justice staff to effectively participate in a youth's recovery from traumatic experiences. This benefit includes potentially substantial long-term economic and social cost savings, as well as the immediate satisfaction of being able to effectively contribute to the public's safety and welfare. Trauma-informed juvenile justice systems help youth and families better understand childhood trauma and its impact on behavior and health. This understanding can help restore relationships by providing a new way for youth and families to understand the trauma they have experienced. A third benefit is the strengthening of the safety net for traumatized youth by providing a basis for a partnership between systems that serve and supervise children, including the education, child welfare, mental health, and justice systems. Aligning their often-different missions around the shared goal of protecting children and youth from victimization can actually shrink, rather than widen, the net in which children are caught if they engage in problematic or delinquent behavior. A shared understanding of psychological trauma and PTSD can provide an alternative explanation for what may otherwise be diagnosed as a psychiatric disorder or sociopathic character flaws (Ford, Chapman et al., 2012; Ford et al., 2013). Protecting children and youth from harm and helping them recover and become successful and productive citizens are points of convergence for all child-and family-serving systems. This can be a basis for developing administrative structures and processes that bring educators, child welfare workers, juvenile justice administrators and staff, and court professionals together as a team on behalf of traumatized youth.

Youth and families with a history of mental illness often find challenges acquiring mental health services needed within their respective communities. Although the need for mental health services and the negative stigmas previously associated with seeking and obtaining care has been targeted for improvement in the public domain, this population continues to be underserved as it relates to community-based treatment. Managing day-to-day family dynamics with untreated mental illness drastically affects, influences and impacts the family's ability to successfully identify and obtain services. These families require needed assistance in navigating what are often complex service systems. This support proves even more critical for families with limited financial resources, leaving law enforcement and the traditional criminal justice system to provide temporary interventions for unlawful acts directly driven by illness.

Supporting Data

Along with the county population, the number of referrals to Collin County Juvenile Probation Department (CCJPD) increased by 45% overall from FY 2016 (n=995) to FY 2019 (n=2,033) with a slight decline due to the pandemic in FY2021 (n=1,593). During this same time period, the number of felony referrals continued to increase.

The nature of the felonies committed has also increased in degree of violence, as opposed to just statutory element. The number of youth referred for aggravated assault, sexual assault, murder, deadly conduct/discharge firearm, and injury with intent increased from FY16 to (with 218) to FY 2019 (with 416) and continues to in FY2021 (n=615). The number of misdemeanor assault charges doubled over the same period. With this increase in serious and violent felonies, the department has and continues its primary function of ensuring community protection for county citizens but attempts to do so in the least restrictive means available for youth and families. A critical component in making informed decisions in this balance requires the agency to look beyond just the criminality of offense and use evidence-based risk and needs assessment findings and targeted-rehabilitation strategies to promote both community-protection and good outcomes. Without a community-based, mental health focused strategy to work with potentially violent, youthful offenders whose behavior can be directly correlated to mental illness, many youthful offenders are left to the counties most cost-prohibitive remedy, which is post-adjudication detention services. Although the program provides clinical services for youthful offenders, the department has seen an increase of approximately 300% for youth whose mental health needs exceeded what could be adequately treated at the time of court disposition FY2021, n=9. All the youth in sample received some level of community-based services prior to being removed from the home although all current local remedies were proven to be unsuccessful. These youth were ultimately placed in secure-mental health treatment facilities across the state and region pursuant to increased efforts to divert felony, violent-offenders away from state commitment pursuant to Senate Bill 1630.

The importance of mental health and access to services is profound as mental health contributes to the crime being committed and the increasing numbers of juveniles. Mental Health is a huge factor in a child's emotional, behavioral, and cognitive well-being.

The need for and lack of comprehensive, coordinated mental health services throughout the life cycle, and especially for children, is underscored by the following information regarding the incidence and prevalence of mental health needs:

- 1.2 million children in Texas have a chronic mental illness (TexMed, 2018).
- 1 in 6 U.S. children aged 2-8 years (17.4%) had a diagnosed mental, behavioral, or developmental disorder (Centers for Disease Control and Prevention, 2018).
- 71% of Texas children under the age of six had not had a single developmental screening (Casey Foundation Study, 2013).
- 9.4% of children aged 2-17 years (approximately 6.1 million) have received an ADHD diagnosis (Centers for Disease Control and Prevention, 2018).
- 7.4% of children aged 3-17 years (approximately 4.5 million) have a diagnosed behavior problem (Centers for Disease Control and Prevention, 2018).
- 7.1% of children aged 3-17 years (approximately 4.4 million) have diagnosed anxiety (Centers for Disease Control and Prevention, 2018).

- Teen depression has increased 59% since 2007 (world Health Organization, 2020).
- 3.2% of children aged 3-17 years (approximately 1.9 million) have diagnosed depression (Center for Disease Control and Prevention, 2018).
- Adolescent children of military parents have greater emotional and behavioral problems than adolescents without military parents (SAMHSA, 2018).
- Nearly 8 in 10 children (78.1%) aged 3-17 years with depression-received treatment (Centers for Disease Control and Prevention, 2018).
- Six in 10 children (59.3%) aged 3-17 years with anxiety-received treatment (Centers for Disease Control and Prevention, 2018).
- More than 5 in 10 children (53.5%) aged 3-17 years with behavior disorders received treatment (Centers for Disease Control and Prevention, 2018).
- In 2019, suicide accounted for 19% of deaths among youth aged 10 to 14, 29% among youth aged 15 to 19, and 23% among young adults aged 20-24.
- 51% of Texas adolescents in grades 7 – 12 have used alcohol and 25% had consumed alcohol in the last month. 26% of Texas Secondary students have used Marijuana (Substance Abuse Trends in Texas: June 2017).
- Left undetected, mental health disorders can have serious consequence such as school failure, teenage childbearing, unstable employment, early marriage and marital instability and violence. Additionally, untreated disorders can lead to more frequent and more severe episodes and are more likely to become resistant to treatment (NIMH, 2017).
- 1 in 6 U.S. children aged 2-8 years (17.4%) had a diagnosed mental, behavioral, or developmental disorder.

Among children living below 100% of the federal poverty level, more than 1 in 5 (22%) have a mental, behavioral, or developmental disorder. Age and poverty level affected the likelihood of children receiving treatment for anxiety, depression, or behavior problems.

The Center for Disease Control and Prevention (2018) analyzed the long-term effect of childhood and adolescent traumatic experiences on adult health, mental health, healthcare costs and life expectancy. Adverse Childhood Experience (ACE) such as emotional, physical, or sexual abuse, emotional or physical neglect, witnessing abuse, household substance abuse or mental illness, parental separation or divorce, incarceration of a family member strongly correlate with an adult's depression, alcohol abuse, illicit drug use, risk intimate partner violence, suicide attempts.

Furthermore, 20% of children have a diagnosable mental disorder with only 1 in 5 receiving help (National Association of Mentally Ill, 2017). The American Psychiatric Association asserts that 15% of depressed individuals will commit suicide and by 2022, depression will be the second largest killer following heart disease ("The Numbers Count: Mental Disorders in America," 2009). In fact, mental disorders represent four of the top 10 leading causes of disability (Centers for Disease Control, 2015).

In 2019, 13.6% of U.S. children between the ages of 5 and 17 years had received mental health treatment in the past 12 months. In total 10% of children had received counseling or therapy from a mental health professional and 8.4% had taken prescription medication for their mental health (National Health Interview Survey, 2020).

At the present time Collin County has 22 juveniles with mental health needs that need assistance with others waiting to be assessed and placed.

Project Approach & Activities

The overall goal of the Juvenile Mental Health Court Program will be the following but not limited to: 1) Treat the underlying cause of criminal behavior; 2) Keep the community safe and decrease recidivism; 3) Hold the juvenile (and parent) accountable and 4) Find solutions that are strength-based, child-centered, family-focused, and culturally appropriate to address mental illness. The JMHC Program will utilize the multisystem approach to help participants with mental health needs. This multidisciplinary team will effectively address the many unique and significant needs of the youths.

JMHC will combine mental health treatment with frequent court appearances, home visits, academic advocacy, case management, counseling, and community based support. The team will consist of a judge, law enforcement, prosecutors, defense attorneys, probation officers, case manager, director of education, treatment providers (psychiatrist and psychologist), and the families. Each member on the team plays a vital role in helping the participant successfully complete the program in his or her home as well as providing protection for the community. Community resources will be used to provide supportive services for the family while decreasing the need of out of home placements.

JMHC will be an intensive supervised program, which will focus on addressing the participant's behavior and mental health problems within the home that impacts the participant's ability to be successful while on probation. The program will not only address how mental illness affects the participants but also how mental illness impacts the entire family.

JMHC uses an integrated treatment approach to address participant's needs. Including but not limited to psychological evaluations, substance abuse assessments, and other behavior assessment tools as directed by the treatment provider.

The JMHC program will be a twelve (12) month program with extensive follow-up depending on compliance with the rules and treatment. There are (4) levels/phases to the JMHC Program. The following will explain the phases in detail:

Phase 1 – Bronze

Bronze is known as the orientation level. During this level, the participant will be introduced to their support team. The strengths and needs will be assessed to help both the participant and family develop a treatment plan. Participants will go through an extensive assessment, followed by individual and family therapy interventions. The participant will meet the case manager for assistance in connecting with community resources.

Phase 2 – Silver

Silver is known as the stabilization level. The participant will begin to work on maintaining their treatment and probation goals, which will map their success toward probation termination. During this level, the participant will work closely with their psychiatrist to assure all medication is working effectively. The participant will be required to attend all doctor appointments and follow all treatment instructions. The participant must show progress before moving to the next phase. Progress towards goals will be determined by status reports from treatment providers.

Phase 3 – Gold

Gold is known as the transition level. The participant will continue to work on coping skills that they have learned to help them function in their community. The participant will continue to take medication as prescribed and attend all counseling as directed by treatment provider.

The participant and parent will attend monthly court hearings. During this phase the participant will complete all of the program goals and discharge plans will be developed. The participant will be assisted in sustaining treatment, increasing compliance with terms and conditions of probation, and identifying factors that may affect mental status upon release from the program.

Phase 4 – Platinum

Platinum is known as the skills level. The participant will continue with working on coping skills. Coping skills that the participant learned throughout the program. The participant will meet with their probation officer monthly for continued monitoring of progress. The participant will continue working with the counselor and utilizing community resources. The participant will continue to take their medication as prescribed by the doctor. They will also continue pro-social activities and meeting with their mentor. Participants will have at least one contact per month with case manager.

Please refer to upload file for program phases detailed.

The program will also have the following for the participants but not limited to: Expectations, Incentives, and Sanctions. Please refer to upload file for explanation of what is expected from each participant.

Capacity & Capabilities

All of the personnel on the JMHC team not only have professional expertise in their field but also have (or will have) significant experience and understanding of mental health and developmental disabilities and how this will manifest within a youth's behavior and within the justice system.

JMHC Treatment Team:

Judge: the Judge will conduct status hearings as ordered. The Judge will encourage the participant to do well and stay on target. The Judge will hold the participant accountable if they fail to comply with the program and/or probation requirements. The Judge will speak with the participant and family to see how they are doing in treatment, at home, school and in the community. They will also ask what the team can do for them and their family to keep on track.

- Honorable Cynthia M. Wheless, Judge 417th Juvenile District Court

Program Coordinator: The Coordinator is responsible for coordinating all of the court activities and serves as a member of the JMHC team. The Coordinator also works directly with the Judge to ensure that the activities of the JMHC are coordinated which include preparing dockets, scheduling and notifying all staff members of review hearings, meetings and screenings.

- Sheila Shaw, JMHC Program Coordinator

Case Manager: the Case Manager is responsible for interviewing participants and family. The case manager will assess their needs, coordinates care within the community, and conducts educational groups. Communicates with treatment providers to determine client participation. Maintains accurate

up-to-date documentation. Case Manager will conduct intensive management skills, monitor the progress of clients served, act as an advocate for client with medical professionals, aid in the development and coordination of treatment plans, and ensure communication with family and agencies.

Juvenile Probation Officer: the Juvenile Probation Officer will meet with each participant to create an individual case plan that will work for them and family so that they will remain focused on completing their goals. The probation officer will be tracking each participants progress within the program and assist them when necessary in order for them to complete the program successfully. The duties of the probation officer also include providing intensive supervision to ensure that they are doing what they are supposed to be doing. The JPO will counsel and confer with juveniles, parents, schools and agencies in order to provide adequate resources. The probation officer will conduct random and observe drug testing on participants based on their level of probation. The Juvenile Probation Officer also attends team meetings, weekly staffing and weekly status court hearings.

Treatment Provider: The Treatment Provider will establish and comprehensive, community-based treatment plan for the participant and for the family pursuant to their mental health evaluation(s)/assessment(s). The treatment provider will also have a designee assigned to the JMHC team. They will provide group, individual and family counseling sessions, and medication management services. They will also provide parenting skill classes and a designee to attend program staffing. Program participants will learn various copings skills on how to manage their emotions as well as ways to become free of drugs. The treatment provider will review the progress towards goals as well as provide weekly reports to the JMHC team regarding progress towards treatment goals, attendance and participation, and provide insight to the team on how best to provide program participants and families support for treatment compliance.

- LifePath Systems

Defense Attorneys: The defense attorney will advocate for the participant and assist with legal matters for the participant that relate to the JMHC program. They will advocate for the participant in court and during JMHC team staffing. The attorney will help to make sure that the participants stay on track to reach their treatment and case plan goals.

District Attorneys: The Assistant District Attorneys serve as members of the JMHC team and assist in assessing cases that appear appropriate for the JMHC. The Assistant District Attorney will have a non – adversarial approach when serving as a JMHC Member.

- Kelly Ludy
- Melinda Brewer
- Paul Anfosso

Director of Education: The Director of Education serves as a member of the JMHC and will coordinate educational guidance for participants and parents. The Director of Education will review transcripts, grades, and classes to assure participants education needs are met. Director of Education will attend and ARD meetings or educational meetings as needed.

Parents/Family: The JMHC relies heavily on the participation of the parents. Parents will play a key role in the success of the program. Parents will be expected to attend all court hearings, family counseling

sessions, parent skills group, and JMHC family activities. They will also be expected to share information regarding the participant's behavior and progress at school, home and in treatment. Parents will be expected to report all probation violations including JMHC program compliance. Family participation is important and is required as part of the program.

Collaborative Partnerships: The program has identified and developed relationships with local resources and organizations that provide ongoing support for the participants and their families.

The JMHC Program has a strong partnership with the following but not limited to: (please refer to attachment A for other Community Partnerships)

- Collin County Child Protective Services
- Collin County Child Advocacy Center (CAC)
- Traffick 9-1-1
- Stride Services (Substance Abuse Treatment)
- Texas Department of Family and Protective Services
- Specialty Courts of Education

Wraparound Services has been recognized as a model for collaboration, integrating mental health, juvenile justice, and child welfare and education systems to provide services to youth (Resource Center Partnership, Models for Change). A model that works and serves the juveniles within the county. The integrated, multi-service approach to meeting the needs of juveniles will include a focus on the family's strength and culture, as well as those of the community. The treatment plans will be tailored to address the unique needs of each juvenile and family.

Performance Management

Goal: Deliver services to youth with cases in the criminal justice system.

Objectives:
1. Ensure minimum of 95% of juveniles (youth) seeking assistance will be served.
2. Demonstrate maximum 10% increase yearly in youth enrollment.
3. Graduate 15 from program.

Measures:
1. Provide assistance/services to 20 juveniles (over the course of the grant).
2. Provide case management and advocacy for 20 juveniles (over the course of the grant).
3. Provide advocacy and assistance for juveniles.
4. Provide treatment referrals for 20 individuals (whether ultimately accepted into the JMHC Program or not) (over the course of the grant and aftercare).
5. Assist 20 juveniles with developing plans (over the course of the grant).

Client outcome measurements will be used to establish and evaluate the program's progress in achieving service goals. The Case Manager along with the Probation officer will analyze the outcomes

and an action plan will be developed and implemented as needed to ensure that objectives are being met. Performance measurement/data will be collected, reported and submitted in a timely matter.

Data Management:

The software applications will provide a platform (Techshare/Noble Software Application) to enter all screenings and account for recidivism rates to track program success, number of youth screened, identified, and served in the program. The department's case management system also tracks and records all demographic information for youth including race, age, gender and educational status. The Collin County Juvenile Probation Services department utilizes Techshare Juvenile Case Management System to collect, report, and manage program data.

Techshare provides enhanced productivity tools and data sharing capabilities; strong security and data integrity. In addition to data maintained in Techshare, the project coordinator will maintain an Excel spreadsheet with the PID of youth obtaining services, offense level committed, dates of services provided, school attendance, grade point averages, re-offense during project, and 1-year post-project recidivism results.

Target Group

The JMHC Program accepts referrals for juveniles, aged between 12 and 17 years, who reside in Collin County and demonstrate mental health issues. The JMHC Program will serve 20 juveniles with mental Health issues over the next twelve to eighteen months. As mental health participants, all are considered high risk and high need. Requested funding will be able to provide services for these participants who would otherwise be unable to participate in the program or receive the assistance they much need.

The program will use a multidisciplinary approach to service delivery, working with all community-based stakeholders serving the youth throughout the community. Some of the agencies that Collin County will be utilize will include but not limited to:

- Collin County Juvenile Probation Department will provide officers to assist with the participants and family.
- Collin County Advocacy Center to provide counseling services to both the participants and family.
- Traffick 911 to provide counseling and education services.
- LifePath Systems to provide mental health services.
- Stride Services to provide outpatient IOP/Substance Abuse services.
- Parents/family: the program will rely heavily on the participation of the family. The family will play a key role in the success of the program.

Evidence-Based Practices

The Collin County JMHC Program recognizes the importance in incorporating current theory, best practice, and evidence-based service delivery. As such, the program staff maintains an updated knowledge base through research and training, informally reviews the program on a continual basis, and formally reviews the program annually, changes are made as needed.

The therapist will utilize the evidence-based treatments that best suit the needs of the juveniles through the phases they need to follow once exiting program. The participants along with family will continue to be monitored. The following are a few of the therapeutic evidence-based service models they will be able to choose and incorporate into their daily lives in order to be productive citizens within the community:

- Group therapy
- Substance abuse
- Support System
- Family Treatment
- Treatment planning (ongoing treatment)
- Alternative therapies (art therapy, music therapy, community service projects, etc.)
- Family Treatment Court Best Practice Standards (NADCP)

The JMHC also recognizes the importance of including the framework and staffing as a best practice. The team members should have the following but not limited to:

- Commitment
- Strong leadership
- Willing to Champion the program
- Leaders within their sector
- Have knowledge and experience with mental health and criminal justice system