



STEMMING THE TIDE

Diverting Youth With Mental Health Conditions from the Illinois Juvenile Justice System

The Illinois Mental Health Opportunities for Youth Diversion Task Force (Illinois Public Act 99-0894), serves as the statewide group mandated to provide an action plan to the Governor and General Assembly for diverting youth with mental health conditions from the criminal justice system.

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- Florida Department of Support Services
- Ogle County, Illinois, Juvenile Justice Council
- Illinois Criminal Justice Information Authority
- Illinois Department of Human Services
- Illinois Department of Juvenile Justice
- Illinois Justice Project
- Illinois State Police
- Juvenile Justice Initiative
- Seventeenth Judicial Circuit Court of the State of Illinois - Winnebago County Mental Health Court
- Oregon State Court Juvenile Justice Mental Health Task Force
- Young Minds Advocacy Project



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Executive Summary

Over the last several years, the number of youth who are jailed or incarcerated in Illinois has declined. This is a success – and only possible because of the deliberate effort to divert youth who do not present safety threats to themselves or the community from further system involvement. Through the collaboration of government, agencies, and advocates, we have seen great progress in keeping youth out of the juvenile justice system. As this downward trajectory continues, a certain population of youth are still entering the justice system at higher rates: those living with mental health conditions. Tens of thousands of youth who are arrested each year meet diagnostic criteria for having a mental health conditions, and at least 20 percent live with a serious mental health condition. Frequently, a youth's disruptive or illegal behavior is related to symptoms of a mental health condition that has gone undetected and untreated. These youth – the majority who have lives already marred by racism, poverty, and violence – then cycle through jails, probation offices, courts, and prisons. The opportunity to divert youth early is wasted, and youth end up in a system that is ill-equipped to provide the necessary treatment.



In fact, the vast majority of youth with mental health conditions are mainly arrested for property offenses and probation or parole violations. Shifting resources from youth with mental health conditions could allow Illinois to focus attention on violent offenders **and improve public safety**. The cost is also greater for other justice-involved youth largely because of the cost of in-facility mental health treatment. In Illinois and throughout the country, we're learning more about **effective youth development** for those with mental health conditions and what puts them on the right path to becoming valued assets in our communities. We must focus on putting youth with mental health conditions on the road to recovery, a road that helps them prevent further contact with the justice system and return to school, work, and family.

The Illinois Mental Health Opportunities for Youth Diversion Task Force was created to identify and recommend diversion programs that will help treat youth with mental health conditions in the community and avoid initial or further involvement in the justice system. At the beginning of the Task Force process, members developed guiding principles which provide a foundation for building a system committed to addressing the mental health needs of youth. The Task Force approached the charge by looking at different points of the justice system – in the community and before any contact with the justice system, at initial contact with law enforcement, jails, courts, and reentry from the system. Along these points, we have reviewed evidence-based models and best practices for diversion opportunities for youth living with mental health conditions and identified funding sources to implement recommendations.

Guiding Principles Focus On:

- Community-Based Mental Health
- Adolescent Brain Development
- Best Practices
- Collaboration
- Family Involvement
- Disproportionate Contact
- Systems of Care
- Linkage
- Evaluation

The Task Force prioritized early intervention, as it provides the best opportunity to divert youth to services that will both impact the quality of their lives and prevent the negative impacts of system involvement. However, youth with mental health conditions are seen across the system and those with significant behavioral health needs are found deeper in the system. Our recommendations present a road map to build a stronger diversion system that addresses youth with mental health conditions specifically.

Summary of Recommendations

1. Improve mental health **screening** for justice involved youth.
2. Invest in **early intervention** for serious mental health conditions.
3. Expand screening and sustain the Illinois **Comprehensive Community-Based Youth Services** (CCBYS) program.
4. Train communities in mental health **awareness**.
5. Expand **Crisis Intervention Team Training for Youth** (CIT-Y) programs across the state.

6. **Avoid the use of arrests** for misdemeanor offenses committed by youth living with mental health conditions.
7. Implement best-practices for new or existing **Juvenile Assessment Center** model programs.
8. **Evaluate the effectiveness of station adjustments** for juvenile offenses.
9. Expand the implementation of **juvenile mental health courts**.
10. Expand funding for the **Mental Health Juvenile Justice Initiative**.
11. Ensure eligible youth are enrolled in **Medicaid** before release.
12. Alleviate the **medication gap** upon release.
13. Ensure **continuum of housing and income** upon release.
14. **Track positive youth outcomes**, not just recidivism.

While recommendations cover a variety of issues for justice-involved youth living with mental health conditions, it was beyond the scope of the Task Force to specifically address or make recommendations on broader statewide issues. Nevertheless, we feel it is important to describe the issues and barriers that currently exist in Illinois, which must be either considered or addressed to fully implement the recommendations made by this Task Force.

JUVENILE JUSTICE SYSTEM**Community**

- Screening
- Early Treatment
- Crisis Identification
- Community Training

Law Enforcement

- Training
- Avoiding Arrest
- Assessment Centers
- Understanding Station Adjustments

Courts

- Expanding Juvenile Mental Health Courts

Reentry

- MHJJ
- Medicaid Enrollment
- Medication Gap
- Continuum of Services
- Tracking Positive Outcomes

Disproportionate Contact Exacerbates Disparity in the Juvenile

Justice System: We must address the impact of poverty and racism in the juvenile justice system and acknowledge the role these factors play in perpetuating mental health conditions among youth and families.

Medicaid is Foundational for Access to Care: Over 1.4 million children and youth are covered by Medicaid in Illinois. Access to services for these youth and many others requires a functioning Medicaid program as the foundation.

Funding for Community Based Mental Health Services: There is a significant shortage of mental health professionals across Illinois. This cannot be ignored as the need for increased community based mental health service for youth living with mental health conditions to support diversion from justice involvement.

Prioritizing Family Inclusion Across All Systems: The family unit has a major impact on youth and engagement with families should be considered a component of meeting their needs.

Diversion Programs Should Reflect Populations Needs and Voice: Leadership should come from youth and families who have experience with mental health conditions, the juvenile justice system, or both. Additionally, the juvenile justice system and clinical interventions should be gender-responsive.

Treating Mental Health Conditions that Co-Occur with Substance Use: For many youth, these conditions are related and connected, and treatment requires a clinical approach that addresses both issues.

Ensuring Diversity in the Mental Health Workforce: Part of the response to disparities in mental health services is access to clinicians that reflect the communities they are serving.

Paying for Prevention and Early Intervention: Reinvestment in diversion and new investment in mental health services are appropriate uses of savings at the local and state levels.

Trauma-Informed Approach: Trauma is a near universal experience of youth with mental health conditions; therefore, we need to ensure that our diversion programs understand the role that events like community violence or substance use in a parent cause youth to grow numb and lead to mental health conditions.

DEFINITION OF KEY TERMS IN THIS REPORT

Diversion programs: alternatives to initial or continued formal processing of youth in the juvenile justice system. Diversion can take place at any point of contact with the justice system: when a youth first enters the system, when they are detained, and/or when they return to their communities. This Task Force is specifically considering diversion to mental health services, but diversion programs generally connect a youth to a variety of services, such as job programs.

Mental Health Condition: encompass all diagnosable mental disorders characterized by alterations in thinking, mood, behavior, and impaired functioning. Symptoms of mental illness are marked by their pervasiveness and persistence. Mental illnesses are common and treatable and people living with mental illness can recover and lead meaningful and successful lives.

Youth: under the age of 18 who are accused of committing a delinquent or criminal act are typically processed through the juvenile justice system. Youth can encompass transition age youth as well, which refers to individuals aged 16 to 25 years, crossing both the juvenile and adult justice systems.

The Problem



A 16-year old teenager sits in his cell in an Illinois detention center, frustrated and agitated. His eyes are glassy from lack of sleep and a daily regimen of mood stabilizers. Like many of his fellow detainees, he grew up in a community that is predominantly poor and people of color. For decades, there has been a lack of sufficient investment in community-based mental health services, and those services that did exist have been slashed. Although his charge was a non-violent property offense, decision-makers decided to keep him locked up. It was in detention—also known as youth jail—where he was first diagnosed by a mental health clinician with bipolar disorder.

He should have been diverted before this point.

Stories like this are all too commonplace for youth living with mental health conditions. Many of these youth would likely not have been involved in the justice system but for the mental health condition itself. In fact, tens of thousands of youth who are arrested each year meet diagnostic criteria for having a mental health conditions, and at least 20 percent live with a serious mental health condition. Their conditions range from major depression, bipolar disorder, attention deficit disorder, to anxiety, not to mention the many other significant conditions that a young person might face. Frequently, a youth's disruptive or illegal behavior is related to symptoms of a mental health condition that has gone undetected and untreated. Instead of treating these instances as an opportunity to connect these youth to effective community-based mental health services they are too often directed toward law enforcement. These youth – the majority who have lives already marred by racism, poverty, and violence – then cycle through jails, probation offices, courts, and prisons. The opportunity to divert youth early is wasted, and youth end up in a system that is ill-equipped to provide the necessary treatment.

The status quo prevents Illinois from realizing the vision of public safety, responsible use of taxpayer dollars, and youth development. Despite sensational stories of violent acts committed by those with mental conditions, arresting youth with mental health conditions **thwarts public safety**. The vast majority of youth with mental health conditions are nonviolent, and mainly arrested for property offenses and probation or parole violations.¹ They are actually far more likely to be *victims* than perpetrators of a violent crime.² Shifting resources from youth with mental health conditions could allow Illinois to focus attention on the most violent offenders and improve public safety.

Putting youth with mental health conditions in jails or prisons is also **costly to taxpayers**. The costs are greater than the other justice-involved youth largely because of the cost of in-facility mental health treatment and longer lengths of stay due to a youth's inability to comply with rules and conditions.

There is also burgeoning knowledge in Illinois and throughout the country about effective **youth development** for those with mental health conditions and what puts them on the right path to becoming valued assets in our communities. It includes knowledge around adolescent brain development, effective community-based mental health treatment, and proper

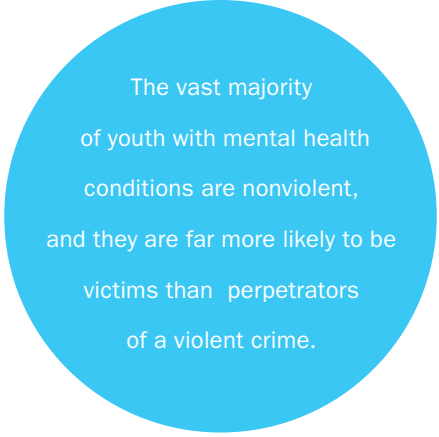
supervision. For these reasons, we must focus on putting youth with mental health conditions on the road to recovery, a road that helps them prevent further contact with the justice system and return to school, work, and family. The crisis is real, and the need to respond is pressing.

Where do we begin?

In this report, the Illinois Mental Health Opportunities for Youth Diversion Task Force responds to this crisis with recommendations, first, for diversion at the community level where there are points of intervention before any contact between young people and the juvenile justice system. The unfortunate reality is that because access to mental health treatment is often limited by factors such as poverty and race, many youth are living with mental health conditions before any involvement in the juvenile justice system. Thus, before any contact with the juvenile justice system, we must ensure youth have access to quality, community-based mental health treatment options.

The Task Force also responds by recognizing that Illinois has never had an adequate mental health system, and its further disinvestment from an already inadequate system puts youth, families, and society at risk. In this context, members of law enforcement act as first responders to mental health crises and jails operate as “dumping grounds” for youth with mental health conditions.³ Today, most youth who are arrested and put in jail have mental health conditions, and many of them are there because of non-violent offenses. In correctional facilities, mental health services are often non-existent largely due to insufficient funding, resources, and trained staff. These facilities were not designed to provide the necessary mental health care, and the services youth do receive are often ineffective and insufficient. Youth with mental health conditions get worse in jail, not better. When youth are not a danger to themselves or others, they should be diverted to community-based mental health treatment.

Whether a young person is detained, awaiting trial, or released in advance of a trial, the petition of delinquency filed by the state’s attorney starts the formal juvenile court process. There are always options for diverting youth with mental health



The vast majority of youth with mental health conditions are nonviolent, and they are far more likely to be victims than perpetrators of a violent crime.

conditions, whether have already been adjudicated delinquent or not. For example, juvenile mental health courts are emerging nationally as an opportunity for addressing underlying causes of criminal behavior through mental health services under the supervision of the court.

Unfortunately, some youth living with mental health conditions will be incarcerated for an extended period. In these cases, it is our responsibility to ensure these youth avoid future involvement in the criminal justice system. Our research shows that the days immediately after a youth is released are a critical period of intervention. Returning youth with mental health conditions face many barriers to successful reentry into the community, including a lack of community mental health providers, health care, job skills, education, and/or stable housing. Any, or all, of these factors may contribute to jeopardizing recovery and increasing the probability of recidivism.

We understand that youth living with mental health conditions will move through the juvenile justice system passing through predictable points. Therefore, we examined specific intercept points within the Illinois juvenile justice continuum where there are various opportunities for diversion:

- **Community Diversion:** The points of contact before any interaction with the juvenile justice system.
- **Initial Contact with Law Enforcement and Jail:** The initial contact a youth has with the police at the time he or she is suspected of a crime, up to the point where a youth is placed in a secure detention setting while waiting for a hearing.

- **Courts:** A petition is filed in juvenile court, adjudication is held, and the judge orders a disposition in the case.
- **Reentry:** The youth is released from a correction placement and returns to the community.

Charge

Using these various intercept points, the Task Force set out to complete our legislative charge:

- Review existing evidence based models and best practices around diversion opportunities for youth with mental health needs from the point of police contact and initial contact with the juvenile justice system;
- Identify funding sources, including funds controlled by the State, counties, and within the health care systems to implement recommendations;
- Identify barriers to implementation and develop sustainable policies and programs addressing these barriers; and
- Deliver an action plan to the Governor and General Assembly with recommendations for increasing the number of youth diverted into community-based mental health treatment instead of further engagement with the juvenile justice system.

Principles

To develop the action plan, the Task Force found it necessary to establish guiding principles that serve as a foundation for building a system committed to addressing the mental health needs of youth:

1. When matters of public safety allow, diversion into **community-based mental health** programs must be a priority of the juvenile justice system.
2. Diversion programs should reflect scientific research showing that a **young adult's brain** is not fully developed until approximately age 25, meaning that young adults act more like adolescents than adults.
3. While local systems and priorities vary across Illinois, there are models and **best practices** that can be elevated to support diversion goals across the state. Broad representation and participation is essential for understanding regional and local context.
4. Multiple systems bear responsibility for these youth. While in certain case a single entity might have primary responsibility, all responses should be **collaborative** in nature, reflecting the input and involvement of mental health professionals, juvenile justice stakeholders, schools, primary care, emergency department staff, and other partners.
5. The **family unit** contributes to the health and stability of youth and must be considered in interventions that address a young person's mental health. Whenever possible, diversion efforts should provide services for both the youth and their family.
6. All mental health services provided to youth should be responsive to populations that experience **disproportionate contact** with the justice system based on ethnicity, race, gender, sexual orientation, socioeconomic status, age, and faith.
7. Creating a **system of care** and strengthening safety net services contribute to youth diversion by meeting mental health needs before crisis.
8. Reducing recidivism is a primary concern for youth who transition out of the juvenile justice system. **Linkage** to mental health services must be as a vehicle for reintegrating youth in the community.
9. Services and strategies in the juvenile justice system should be routinely **evaluated** for effectiveness in identifying and treating youth with mental health conditions.
10. The work of the Task Force does not happen in a vacuum. The lessons learned must be shared with both stakeholders and policymakers to **inform** other efforts and responded to a changing environment.

Much of what is presented in the action plan will have implications for clinicians and agency staff. However, the plan is primarily oriented to policymakers and the juvenile justice and mental health administrators who are responsible for establishing, modifying, and overseeing services.

Recommendations

Based on this frame, the Task Force recommends the following action plan to dramatically increase the diversion of youth from the justice system in Illinois:

1. Improve mental health **screening** for justice involved youth.
2. Invest in **early intervention** for serious mental health conditions.
3. Expand screening and sustain the Illinois **Comprehensive Community-Based Youth Services** (CCBYS) program.
4. Train communities in mental health **awareness**.
5. Expand **Crisis Intervention Team Training for Youth** (CIT-Y) programs across the state.
6. **Avoid the use of arrests** for misdemeanor offenses committed by youth.
7. Implement best-practices for new or existing **Juvenile Assessment Center** model programs.
8. **Evaluate the effectiveness of station adjustments** for juvenile offenses.
9. Expand the implementation of **juvenile mental health courts**.
10. Restore funding for the **Mental Health Juvenile Justice Initiative**.
11. Ensure eligible youth are enrolled in **Medicaid** before release.
12. Alleviate the **medication gap** upon release.
13. Ensure **continuum of housing and income** upon release.
14. **Track positive youth outcomes**, not just recidivism.

Finding a Solution



To meet the charge of the General Assembly, the Task Force followed an action-oriented process by focusing on a common set of goals and values to inform our understanding of diversion programs. With a diverse set of stakeholders at the table, the Task Force was able to discuss our goals from a variety of vantage points. Task Force members come from different geographic locations across Illinois, serve diverse populations, and work across the juvenile justice system. Participation of community members in Task Force meetings and informal discussions with justice involved youth both currently in the community and incarcerated were crucial to our understanding. The diversity of viewpoints contributed to robust and thoughtful conversations around opportunities to support justice involved youth living with mental health conditions.

The first step taken by the Task Force was envisioning a successful system of diversion. Members took this as an opportunity to identify the goals and values shared by the group as outlined by the guiding principles listed in the introduction section. These shared principles steered the conversation around different diversion models. Although not every principle is apparent in each of the recommendations set forth by this Task Force, all measures represent our highest objectives for diversion efforts across Illinois.

To best understand the current challenges and opportunities for developing and expanding diversion programs in Illinois, the Task Force focused on three action-areas: 1) **reviewing data** related to justice involved youth living with mental health conditions; 2) **reviewing diversion programs** both locally and nationally; 3) **diving deeper** into diversion programs for potential recommendations.

Why Did We Apply the Sequential Intercept Model?

The juvenile justice system is complex and has many parts. A youth first encounters the justice system if they interact with law enforcement. From there, many paths exist, leading to further justice involvement or diversion from the system.

When thinking about diversion, there are several points in the juvenile justice system where a youth's trajectory can change. In the community, access to mental health services through school or a community based provider can prevent symptoms and behaviors that might lead to justice involvement. If a police officer is well trained to recognize the signs of a mental health condition, the officer might link individuals to treatment as opposed to arresting them and so forth. Opportunities for diversion in the justice system have been defined by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) through its Sequential Intercept Model.⁴ At each point in the justice system, there is a chance to recognize youth where the most appropriate intervention is mental health treatment in the community.

What Do the Intercept Points Represent?

The Task Force used the Sequential Intercept Model to understand these intercept points and organize our work. Our first step was to learn more about the youth at each of these points to better understand the target populations of different diversion programs. The data illuminated disparities that exist in the juvenile justice populations, particularly related to the prevalence of mental health conditions that justice-involved youth experience.

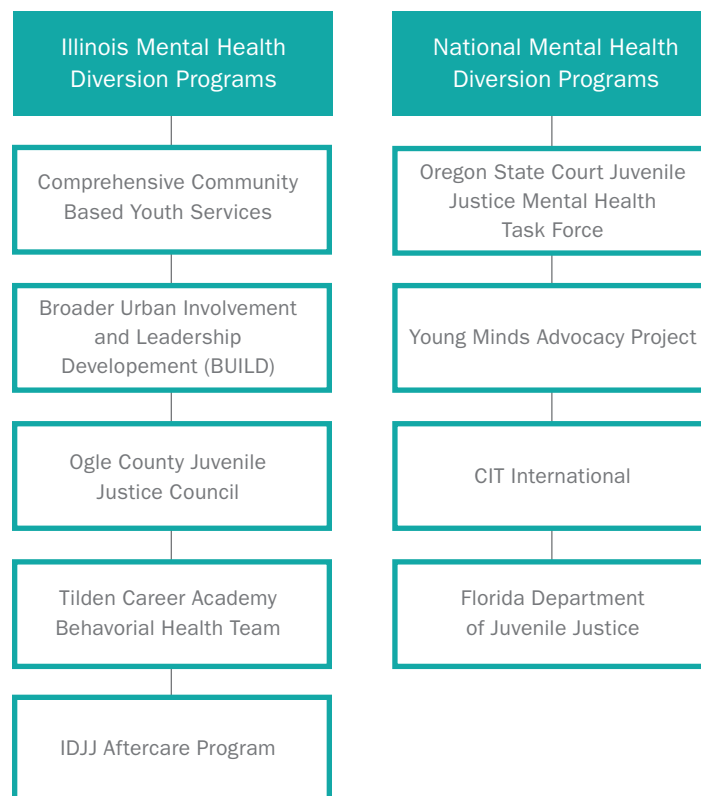
- **Intercept 0:** This point of diversion is in the community before any justice involvement. The biggest opportunities for prevention are at this point. A key issue at this point is that youth from diverse racial and ethnic groups and families who face language barriers are less likely to receive services for mental health problems than white youth.
- **Intercept 1-2:** The first point in the justice system is Intercept 1, which includes the use of 911 and interaction with local law enforcement. Intercept 2 is when a youth can be initially held in jail and could include a first court appearance. Of youth with mental health diagnoses in the juvenile justice system, only 64% reported receiving mental health services previously.
- **Intercept 3:** At Intercept 3, a youth might be held in jail, could go through the court process, and potentially be sentenced to the Illinois Department of Juvenile Justice. Currently, 95% of youth in Illinois Youth Centers have one or more diagnosable mental health condition.⁵
- **Intercept 4:** This point considers the path to re-entry for youth leaving some form of detention. In 2015, about 60% of youth at Illinois Youth Centers received monthly individual mental health services while incarcerated.
- **Intercept 5:** Intercept 5 represents community corrections, such as probation, where youth have some continued connection to the justice system in the community. Of youth exiting IDJJ in 2013, 58.7% returned within three years, suggesting there are deficiencies in the services available to these youth.

What is happening now?

Given our understanding of the extent of mental health conditions among justice involved youth, the Task Force then explored the diversion models used in Illinois. Before the Task Force work began, **a report⁶ was commissioned by the Michael Reese Health Trust, NAMI Chicago and the Sargent Shriver National Center on Poverty Law to survey the scope of diversion programs in Illinois.** The report found that the most effective treatment models demonstrating delinquency-reducing benefits for justice-involved youth with mental health conditions were community-based and dealt with the youth's problem behaviors as a family unit. The Task Force used this information as a starting point.

With a baseline of information for a broad set of diversion programs, the Task Force held panels with program experts to better understand the goals and objectives of a sample of the programs. These panels focused on strengths and challenges of current diversion models, allowing the Task Force to think about areas for potential recommendations.

EXAMPLES OF DIVERSION PROGRAMS EXPLORED BY THE TASK FORCE



What are the biggest needs?

Based on all the information collected, the Task Force broke into smaller Action Teams to learn more about specific diversion programs and make recommendations for actions to increase diversion activities in Illinois. These three groups were based on the Sequential Intercept Model and included Community Diversion, Law Enforcement and Jail, and Reentry.

Each of the Action Teams met between August and November (2017) to discuss various models aimed at the relevant intercept points. The Action Teams included individuals on the Task Force, as well as additional participants and expert speakers. They were chaired by:

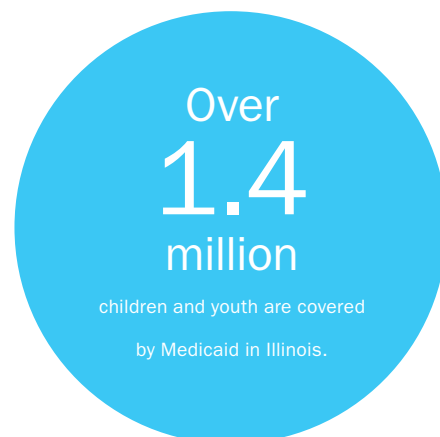
- **Community Diversion:** State Senator Donne Trotter and Rebecca Levin (Strengthening Chicago's Youth)
- **Initial Contact with Law Enforcement and Jail:** State Representative Deb Conroy and Brandy Brixy (Cook County Public Defender's Office)
- **Courts Through Reentry (Intercepts 3-5):** Brian Conant (Cook County Juvenile Temporary Detention Center) and Robert Vickery (Illinois Department of Juvenile Justice)

After the initial work began, discussions around the Court intercept were separated from the Reentry group, allowing Reentry to focus solely on Intercepts 4 and 5. Groups met either by phone or in-person to interviewing subject matter experts on different models and discuss the implications of various recommendations. The full Task Force met in November 2017 to discuss preliminary recommendations and Action Teams continued their work as needed based on those discussions. The results of the work done by the Action Teams are the recommendations set forth in this document.

Impact of Statewide Issues



During the Action Team conversations, a variety of issues were raised that underpin the work of the Task Force. These concerns and barriers are shared for readers to understand the work that must be done to ensure our recommendations are implemented. While the Task Force was unable to tackle these issues specifically, they are foundational to the success of the recommendations.



Disproportionate Contact Exacerbates Disparity in the Juvenile Justice System

Disproportionate contact refers to rates of contact with the juvenile justice system among juveniles of a specific minority group that are significantly different from rates of contact for white non-Hispanic juveniles. Most often this refers to race and ethnicity, but disproportionate contact can occur among youth by gender, sexual orientation, socioeconomic status, age, and faith. These disparities are not new – government entities and advocates have recognized these significant disparities for decades.⁷ Underlying this issue are many things, but institutional, structural racism and poverty are among the issues that must be acknowledged. These factors not only contribute to disparities in justice involvement, but “racism and racial discrimination adversely affect(s) mental health, producing depression, anxiety, and heightened psychological stress in those who experience it.”⁸ As a state, we must address the impact of poverty and racism in the juvenile justice system and acknowledge the role these factors play in perpetuating mental health conditions among youth and families.

Medicaid is Foundational for Access to Care

The intersection of juvenile justice and the mental health system is access to services. The availability of mental health services for youth and young adults can prevent justice involvement by treating symptoms, providing appropriate supports, and reducing behavior that looks criminal but stems from mental health conditions. Our public health coverage programs, Medicaid, and All Kids for children and youth (known as the Children’s Health Insurance Program, or CHIP, at the federal level), is fundamental to providing access to services. Over 1.4 million children and youth are covered by All Kids in Illinois, which amounts to 45% of Medicaid enrollees⁹ and 50% of the state’s population under 18.¹⁰ In 2016, 44% of the Medicaid expansion population was between 19-34 years old, representing over 287,000 individuals.¹¹ Illinois continues to rely on the Medicaid program to maintain even the current level of mental health and substance use services available. Innovation and advancement in quality and efficiency is needed in the Illinois Medicaid program, and while there are efforts underway to address these very issues, they still require a functioning Medicaid program as the foundation. Let this be a reminder that we must champion our Medicaid program, the Medicaid expansion, and All Kids in Illinois as the gateway to healthcare access for millions of Illinoisans.

Funding for Community Based Mental Health Services

The U.S. Department of Human Services states that nearly 5 million people in Illinois live in areas where there are not enough mental health professionals.¹² This cannot be ignored as we emphasize the need for community based mental health services to expand access and increase capacity to provide an alternative to justice involvement for youth living with mental health conditions. Although this is a complex issue, it is worth noting that there are several avenues for improving mental health capacity in the community, including evaluating rates mental health professionals receive through the Medicaid program and commercial insurance, ensuring parity in both public and private health plans, ensuring coverage of mental health and substance use treatment models through both public and private health plans, and investing in workforce capacity through loan forgiveness, incentive programs, and telehealth opportunities.

Prioritizing Family Inclusion

As noted in our guiding principles, the inclusion of families in diversion efforts is critical. Across the recommendations, we've noted points where family involvement must be considered for successful programming. As noted in the report provided to this Task Force, the most effective treatment models demonstrating delinquency-reducing benefits for justice-involved youth with mental health conditions are community-based and deal with the youth's behaviors as a family unit. Silos within our system exist that make engaging a youth and their families for all of their needs challenging. However, we know that the family unit has a major impact on youth, and therefore should be considered a component of meeting their needs.

Diversion Programs Should Reflect Populations Needs and Voice

While recommendations in this report speak to specific diversion programs, populations that are impacted by the juvenile justice system should be integral in decision-making around implementation of programs. When tailoring to community needs are referenced in this report, emphasis must be put on leadership from youth and families who have experience with mental health conditions, the juvenile justice system, or both. There is opportunity for inclusion and

leadership through many juvenile justice and mental health stakeholder groups currently operating in Illinois.

Additionally, there is increasing discussion and research around gender-responsiveness within the justice system. Studies show that boys represent 83% of arrests for violent crimes while girls make up 61% of all runaway cases.¹³ Boys and girls react differently to system involvement because of physiological, sociological and developmental differences.¹⁴ For these reasons, the system must be responsive to boys and girls differently, both in general practices and through interventions. While research on programs for girls is behind programming for boys, those that are gender-responsive for girls include "being strength-based, trauma-informed and relational, ensuring physical, psychological and emotional safety, employing staff who are sensitive to trauma and understand girls' socialization and providing ongoing staff training and support."¹⁵ This approach should be pervasive across the system and must ensure youth participate according to their gender identity.

Treating Mental Health Conditions that Co-Occur with Substance Use

Although the charge of this Task Force focuses on youth living with mental health conditions, we understand and acknowledge that many youth also struggle with substance use or may use substances to self-medicate. Within the juvenile justice system, studies show that of youth with a mental health diagnosis, 58.5 percent of males and 65.6 percent of females also had a co-occurring substance use disorder.¹⁶ This is of increased concern due to the opioid crisis, where opioid overdoses deaths, specifically from heroin, were the highest for those aged 15 – 19 in 2015.¹⁷ For many youth, mental health and substance use conditions are connected and treatment requires a clinical approach that addresses both issues. Interventions that address mental health needs for justice involved youth should also assess for substance use needs, and treat as co-occurring disorders if indicated.

Ensuring Diversity in the Mental Health Workforce

We know that communities of color are disproportionately impacted by the juvenile justice system and that justice-involved youth experience high rates of mental health

conditions. Research also shows that “racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated. Further, people of color [in the United States] are more likely than whites to delay or fail to seek mental health treatment.”¹⁸ Part of the response to these disparities in mental health services is access to clinicians that reflect the communities they are serving. Policy recommendations for improving health disparities include “increasing the proportion of racial minority providers...where diversity may make more of a difference in addressing minority patients’ concerns about trust...A more diverse workforce would likely provide not only more culturally appropriate treatment, but also language skills to match those of patients.”¹⁹ A 2013 report from the Substance Abuse and Mental Health Services Administration (SAMHSA) to Congress found that:²⁰

- The substance use treatment workforce is primarily female, older, and Caucasian, differing from their predominantly young, male, and minority clientele.
- There is a scarcity of providers who can render culturally competent services for minority populations, which contributes to the current disparities in mental health and substance use treatment and services.
- There is a severe shortage of Latino professionals working in behavioral health. Latino clinical psychologists only comprise about 1% of that sector of the U.S. health care workforce.

There are several SAMHSA sponsored programs to increase diversity in the mental health workforce. Illinois must be supportive and engaged in these efforts. Increasing diversity and cultural competency should be a priority in our efforts to improve and expand the mental health workforce, a strategy to reduce inequality in accessing mental health treatment, and a response to community needs and preferences.

Paying for Prevention and Early Intervention

Taken as a whole, these recommendations seek to prevent youth from incarceration in institutional facilities that accrue significant cost to the state. We’ve seen a 44% decrease in the population of youth housed in the Illinois Department of Juvenile Justice facilities (IDJJ),²¹ and still almost 95% of youth in custody have one or more diagnosable mental health conditions. These numbers show there is more work to be done in diverting youth living with mental health conditions from incarceration, which has saved the state over \$100,000 for each youth served in the community as opposed to IDJJ.²² Savings may be accrued at earlier points in the system over time, such as at arrests, probation, detention, and in court. When youth are diverted to the community, the cost of justice proceedings is reduced and the entity incurring the savings might change (from state to county for example). It is important to consider where these savings should ultimately go. The Task Force believes reinvestment in diversion and new investment in mental health services are the appropriate uses of savings at the local and state levels.

Trauma-Informed Approach

Trauma is a near universal experience of youth with mental health conditions. Some are obvious, like a natural disaster that destroys a home, physical abuse or death of a parent. Others can also rock a youth’s sense of safety and well-being, like community violence or substance use in a parent. Trauma can cause youth to grow numb to the violence and crime that besiege their communities and lead to mental health conditions. For these reasons, Illinois should consider the need for trauma-informed approaches when addressing mental health needs to help youth fully recover.

Roadmap for Building a Stronger Diversion System



Based on the many hours of exploration conducted by the Task Force, the recommendations described below represent opportunities for increasing diversion across all points of the juvenile justice system, including:

- **Community Diversion:** The points of contact before any interaction with the juvenile justice system.
- **Initial Contact with Law Enforcement and Jail:** The initial contact a youth has with the police at the time he or she is suspected of a crime, up to the point where a youth is placed in a secure detention setting while waiting for a hearing.
- **Courts:** Where petition is filed in juvenile court, adjudication is held, and the judge orders a disposition in the case.
- **Reentry:** Where the youth is released from a correction placement and returns to the community.

These recommendations seek to connect the dots between mental health services appropriate for youth at points within the juvenile justice system where additional or expanded programs are needed. We've recommended programs that focus on training and educating key stakeholders about mental health conditions and treatments. Furthermore, systematic changes could establish a reliable and strong connection between justice-involved youth and mental health benefits available to them. Through both policy and programmatic changes, we lay out a roadmap that bolsters diversion for justice involved youth in need of mental health services.



A. Community Diversion

Many youth today are living with mental health conditions before any involvement in the juvenile justice system. Researchers estimate that 20 percent of the general youth population has a diagnosable mental health condition, and 10 percent of the general youth population has a serious mental health condition.²³ Despite these facts, 75 to 80 percent of youth in need of mental health services do not receive them at all.²⁴

The majority do not receive treatment because access to mental health treatment is often predicated on factors that include race, class, and gender, among others. For example, communities of color are often less likely to receive treatment for their mental health condition than white youth: 31 percent of white children and youth receive mental health services while 13 percent of children from diverse racial and ethnic backgrounds receive mental health services.²⁵ Further exacerbating the issue of poverty and mental health treatment access, 21 percent of low-income youth live with mental health conditions, the majority of which live in households with incomes at or below the poverty level.²⁶

These communities have borne the brunt of insufficient programs and policies regarding young people with mental health needs because of the insufficient health screening before justice system involvement. There has not been sufficient invested in early intervention for serious mental health conditions, so the focus must be to expand and sustain effective programs that divert youth on the front end. One necessary step is to train community members to recognize and understand how to support youth living with mental health conditions. Furthermore, when matters of public safety allow, youth must be diverted into community-based mental health programs instead of being funneled into the juvenile justice system. Therefore, the Task Force makes the following recommendations for community diversion of youth living with mental health conditions.



75-80%
of youth do not receive needed
mental health services.

RECOMMENDATION 1: Improve Mental Health Screening

Background

For too many young people, their mental health condition is not identified until contact with the justice system, where a trained professional can identify the condition for the first time. Sometimes, the mental health condition itself precipitated the young person's contact with the justice system.

There is a better way. Mental health screening and early identification can and should occur **before** a young person experiences a crisis. For instance, providing treatment for a young person who is acting aggressively in response to trauma can provide a route to health and recovery. For individuals experiencing symptoms that result in interaction with the justice system, arrest and incarceration are likely to exacerbate the underlying cause.

Changes Needed

1. Incorporate Justice-Involved Youth in Mental Health Screening Initiatives

In the last several years, Illinois has adopted several policies that support improving mental health-related screening for children and adolescents, and details regarding their implementation are still being developed. These policies include:

- An amendment to the Illinois Health Statistics Act (Public Act 99-927), which became effective in June 2017, requires age-appropriate social and emotional screening as part of school health examinations. The Department of Public Health is charged with adopting rules still under development.

- The Advisory Council on Early Identification and Treatment of Mental Health Conditions Act (Public Act 100-184) creates an Advisory Council focused on mental health identification in primary care settings and will be appointed in early 2018.
- The lawsuit in *N.B. v Norwood* seeks to require a behavioral health continuum of care, including screening and assessment, for Medicaid-eligible children. The Department of Healthcare and Family Services is required to develop an Implementation Plan by the end of 2018.

The Task Force recommends that implementation of these efforts include the following: (1) data regarding the prevalence of mental health condition among justice-involved youth and (2) opportunities for improving the screening process wherein youth who are at risk of mental health conditions are identified and interrupted in their potential trajectory towards justice involvement.

2. Measure the Impact of Screening on Future Justice Involvement

The Task Force further recommends that any efforts to improve mental health screening for youth should include measurements of the extent to which the improvements actually reduce youth involvement in the justice system. Although extensive information is available about improved mental health screening in primary care, schools, in juvenile justice settings, little is known of how to improve community-based universal screening in a way that reduces youth justice involvement. For example, we are unaware of research that indicates why one screening tool is better than another in identifying youth who are at risk of involvement in the justice system due to mental health issues. As Illinois implements the policy improvements described above, exploration of this intersection will provide an opportunity to develop and test innovative strategies.

Funding

Federal Medicaid and Children's Health Insurance Program (CHIP) reimbursement is likely to be the most promising sustainable funding strategy. However, there is significant uncertainty around federal Medicaid policy. Screening improvements that prevent youth involvement in the justice

system could result in potential cost savings due to reduced incarceration. It costs over \$100,000 per youth housed in the Illinois Department of Juvenile Justice annually and community based services typically cost less than 10% of that amount.²⁷ Creative approaches to braid and blend funding across juvenile justice and health streams should be explored.

RECOMMENDATION 2: Invest in Early Intervention for Serious Mental Health Conditions

Background

Youth living with serious mental health conditions (e.g., bipolar disorder, major depression, schizophrenia) are at higher risk for justice involvement when compared to the general population.²⁸ Psychosis, a serious mental health condition which causes distortions to a person's perception of reality including hallucinations and delusions, is rare, but a study of almost 17,000 detained and incarcerated youth in 2008 found the rate of psychosis was ten times that of the general population.²⁹

Early intervention with youth developing serious mental health conditions—particularly psychosis—can reduce the lifetime severity of those illnesses. It can also prevent future contact with the justice system and can result in fewer hospitalizations, increased participation in the workforce, and, ultimately, reduced lifetime cost for the care of these individuals.^{30,31}

Evidence-based models for early intervention with youth experiencing a first episode of psychosis follow an approach called Coordinated Specialty Care (CSC). This collaborative model involves multiple components:

- Individual psychotherapy
- Family education and support
- Case management
- Supported employment and education
- Medication
- Community outreach, engagement, and education

Many of these essential components of CSC, such as services provided to family members and the intensive team approach, are not typically covered under Medicaid, and even fewer are covered by commercial health insurance. But the impact can be

significant. For example, access to employment and education services can help youth engage in productive activity that is meaningful to them, and can be a major motivator in recovery.

Illinois has utilized federal Community Mental Health Block Grant (MHBG) funds to provide scaffolding for these services. States are currently required to utilize 10 percent of these funds to support CSC programs for those experiencing a first episode of psychosis. Since 2016, Illinois has provided training and technical assistance to 11 agencies that have launched 12 programs in the state. These federal funds also support some of the service components that are not funded by insurance, like community outreach and education.

Over 3000 individuals will develop psychosis in Illinois in a given year.³² And, while there are 12 programs currently operating in Illinois, many geographical areas do not have access to a specialized first episode program (FEP). The ability to develop and sustain additional programs will be essential in achieving positive outcomes. Illinois acknowledged the need to expand these services, when it included a demonstration request in the 1115 Waiver application³³ submitted to the federal government in October of 2016 to further implement first episode psychosis programs.

Changes Needed

1. Expand Access to Early Intervention Services

To maximize the availability of early intervention services in the most effective and financially sustainable manner, we propose that CSC-FEP treatment be paid as bundled, comprehensive services through Medicaid and private insurance. This would be similar to the model used to fund Assertive Community Treatment³⁴ as an intensive, interdisciplinary service. CSC is the accepted best-practice approach for early intervention in psychosis. In addition to the components listed previously, CSC models have been enhanced with peer support, multi-family groups, occupational therapy, and cognitive behavior therapy.

Funding

The Centers for Medicare and Medicaid Services, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Agency provide guidance

for leveraging federal funding that may be used to maximize dollars regardless of the results of Illinois' 1115 Medicaid Waiver.³⁵ Some states have used state or local general funds to supplement federal or other funding sources, including a \$6.75 million investment from New York.³⁶ The investment is sound as the annual cost of providing CSC services for a year is approximately \$15,000 per year,³⁷ which is significantly less than the cost of incarceration³⁸ or of repeated hospitalizations. Therefore, investment in CSC is a reallocation of funds, rather than a new investment.

RECOMMENDATION 3: Expand Screening and Sustain the Illinois Comprehensive Community-Based Youth Services (CCBYS) Program.

Background

Illinois established the Comprehensive Community-Based Youth Services (CCBYS) program in the early 1980s as the state system response for youth and families in crisis that were not already involved with the Department of Children and Family Services (DCFS). The CCBYS program serves youth 11-17 years old that are at risk of involvement in the child welfare and/or juvenile justice system with the overarching goal of family reunification, stabilization, preservation or independence. A continuum of services is available to these youth in accordance with their needs. When appropriate, services are also available to the youth's family. A 24-hour crisis intervention referral system is available for emergency and non-emergency situations and referrals come from a variety of systems that touch youth.

The program focuses on youth in crisis who are at immediate risk of involvement in the child welfare system because they have either: run away from home, been "locked out" of their homes by their parents (often by refusing to pick them up from police stations, detention centers, or psychiatric hospitals), or are in immediate physical danger and beyond the control of their parents. Other at-risk youth may be served as resources allow, including but not limited to those who are truant from school, are homeless and unaccompanied by their families, or are on probation or parole. Every community in Illinois has an identified CCBYS provider.

CCBYS serves approximately 5,700 youth each year. Law enforcement and schools have come to depend on the CCBYS program for assistance, with over 70 percent of the referrals to the program coming from those two sources. Over time, the program has been shown to be enormously successful at its goals of diverting youth from child welfare and the juvenile justice system. Almost 93 percent of youth served in FY2016 were in a family or long-term living arrangement at program discharge, while 2.1% of youth had been referred to DCFS and 0.9% of youth served were in secure confinement (IDJJ, detention center or municipal lock-up).³⁹

CCBYS performance data from 2015 includes the following:⁴⁰

- 7,020 youth were served in the CCBYS Program in 2015
- 5,001 youth exited the program in 2015
- 88.4% of youth with a case plan successfully completed that case plan
- 93.09% of youth with identified mental health needs received services to address those needs
- 79.99% of youth with identified substance use needs received services to address those needs
- 93.13% of youth with identified chronic truancy needs received services to address those needs
- 95.72% of youth with identified trauma needs received services to address those needs
- 84.87% of youth with identified learning disability needs received services to address those needs

Of the total youth served, approximately 30 percent have identified mental health needs, 20 percent have identified substance use treatment needs, and about 27 percent have identified trauma histories, with these needs overlapping for some youth. Addressing these issues in young people can be a key factor in preventing delinquent behaviors.

Changes Needed

1. CCBYS Can Provide a Statewide Response to Youth Living with Mental Health Conditions in Crisis and At Risk for Justice Involvement.

While CCBYS is not a direct provider of mental health, trauma or substance use treatment, the CCBYS program and its' statewide network of service providers is well-poised to be an early identification system for youth who may be on a path to delinquency or need mental health, trauma, or substance use services. The 24/7 statewide infrastructure already exists within the CCBYS system and is staffed by well-qualified professionals with experience interacting with youth and families in crisis. With increased funding, CCBYS providers could expand front-end crisis and non-crisis response services, functioning as diversion programming, in collaboration with juvenile justice agencies that could include individualized case management and linkages or referrals to more intensive mental health services.

2. Invest in the CCBYS System.

Today, CCBYS is primarily funded through General Revenue dollars, with the Department supplementing a small portion of each award with Title XX Donated Funds Initiative (DFI) dollars. CCBYS providers are required to match the state and Federal dollars, usually by applying to the United Way or other fundraising such as philanthropic funds. The program's funding over time has remained stagnant, with FY18 funding accounting for only a 0.57% increase over FY10 funding. This translates to real declines, as provider expenses have grown during this period. The program is vulnerable to cuts as the state's fiscal crisis continues, and demands for General Revenue funding increase. Adequate funding is needed for the CCBYS system to provide resources and support to this population of youth and their families.

3. Assist CCBYS Agencies in Billing Medicaid for Services.

The state's plan for human services transformation indicates a need for mobile crisis response, crisis stabilizers, and intensive in-home services for youth aged 11-17 (and possibly even 10-year-olds).⁴¹ The CCBYS program could potentially meet that need if these services are deemed Medicaid billable; however,

as the CCBYS program currently exists, most services are not Medicaid eligible and very few providers are ready and able to bill Medicaid. To address this, significant up front technical assistance and financial investment is needed for the CCBYS program. While billing for these services is contingent on approval of Illinois 1115 Waiver application, investment in technical assistance can and should begin to ensure providers have the time, capabilities, and capacity to become Medicaid billable.

4. Utilize Enhanced Match Funds to Expand Services

Reinvest funding captured by the Medicaid match into the CCBYS program can help sustain and increase the availability of these resources to youth throughout the state of Illinois. With this reinvestment, we recommend prioritizing youth living with mental health conditions who are at-risk of crisis and expanding the at-risk population served through CCBYS to 18-year-olds. These changes create an opportunity for youth living with mental health conditions – who are more likely to be justice involved – to be linked to services at initial risk, potentially avoiding system involvement. The inclusion of 18-year-olds acknowledges that while they may legally be adults, their brain development is not complete and full executive functioning has not been achieved. In crisis, these youth have similar needs as those traditionally served through CCBYS. To be able to serve youth living with mental health conditions at risk of crisis, the 1115 waiver and state plan amendments will need to be accepted and the definition of crisis will need to be broadened to include more colloquial definitions, as opposed to an explicitly medical or psychiatric definition.

Funding

As described above, funding for the CCBYS program currently comes from General Revenue Funds, a small portion of Federal funds, and CCBYS providers. Recommendations presented here are generally contingent on the approval of the Illinois 1115 Waiver application. However, initial funding is needed from the state through new appropriations to support the Medicaid readiness work. This would represent a substantial change for most providers. Additionally, future funding for the CCBYS program must blend Medicaid dollars with state

funding to ensure that the savings generated by the Medicaid reimbursement would be utilized to sustain this new work. This approach is currently used by Wraparound Milwaukee and blends Medicaid and other funds to provide comprehensive wraparound services to a similar target population.⁴²

RECOMMENDATION 4: Train Communities in Mental Health Awareness

Background

Research has shown that early identification of mental health conditions can lead to increased success in outcomes and recovery.⁴³ Linking youth to services is crucial to ensuring that symptoms are managed. Often it is family, friends, or community resources that interact with youth during the early stages of a mental health condition. For this reason, it is important for community members to be able to recognize the signs and symptoms of a mental health condition and identify resources for services and treatment.

In a recent report by the Kennedy Forum Illinois, mental health awareness trainings were evaluated for attitude shifts during a pilot project conducted on Chicago's west side. Although not all the trainings were youth specific, the outcomes show important increases in positive attitudes and knowledge. For example, participants were assessed for stigmatizing attitudes relating to mental health both before and after trainings. After the trainings, stigmatizing attitudes scores decreased a statistically significant degree.⁴⁴ Stigma around mental health conditions continues to be a barrier to care, and efforts in normalize mental health conditions are vital to reducing these barriers.

Additionally, research related to public stigma reduction conducted by Dr. Patrick Corrigan, et al., has found that “both education and contact had positive effects on reducing stigma for adults and adolescents with a mental illness.”⁴⁵ The research also found that face-to-face contact with an individual living with a mental health condition is more effective in reducing stigma related to mental health than contact with an individual that is recorded and shown by video.

According to research by Anthony Jorm, mental health literacy is a policy priority gaining more attention globally.⁴⁶

In Australia, Canada, and Scotland, plans have been developed to improve mental health literacy to help increase prevention and early intervention. The Obama Administration called for Mental Health First Aid trainings for teachers, other school staff members, and police officers before Congress began appropriating funding.⁴⁷

The Illinois General Assembly has opined on mental health training programs through the passage of Public Act 098-0195, seeks to train individuals in the community to assist someone who is developing a mental health condition or an alcohol/substance use condition. The Illinois Department of Human Services has also set a long-term goal of reducing stigma through education and other evidence-based interventions.⁴⁸ Efforts to increase mental health awareness in the community are in-line with both initiatives.

Changes Needed

For communities to be able to act early on behalf of youth developing or living with mental health conditions before the need for law enforcement intervention, investment should be made in mental health training that helps communities identify mental health signs in youth. Trainings should be viewed as a resource for individuals working with youth, as well as for the youth themselves. Knowing that there are a variety of training options for mental health awareness, and communities have different needs, a community-centered approach to training should be taken.

1. Implement a Tiered Training Program for Mental Health Awareness Training

We propose the implementation of a tiered training program in Illinois that would focus on community needs and capacity. The target audience for trainings should be school personnel, community based organization staff, faith based organizations, parents and high school aged students, and should allow for local entities to determine the approach that best meets their needs. For example, the issue of stigma around mental health can be very complicated, particularly in communities of color. The approach for raising awareness about mental health conditions must then change to acknowledge the cultural norms around mental health.

2. Utilize a Flexible Training Model

We propose utilizing a flexible training model that allows for appropriate training to be provided based on time, audience, and needs of the community. Within this flexible model, we envision three buckets of trainings that might be appropriate for communities:

- i. **Mental Health Overview:** these trainings are typically an hour or less and focus on introducing mental health. Participants should generally understand mental health, have an understanding of symptoms related to common mental health conditions, become aware of barriers to care, and learn about one or more community resources to support individuals developing or living with mental health conditions.
- ii. **Intermediate Mental Health Training:** these trainings range from 2-4 hours. Participants should be able to define mental health, understand the symptoms related to various mental health conditions, and be able to connect individuals to resources in the community. Participants might also be able to understand the impact of trauma and substance use on mental health conditions. Understanding mental health emergencies and what to do in a crisis might also be included.
- iii. **In-Depth Mental Health Training:** these trainings are typically day-long (8 hours) and provide in-depth information about mental health and substance use conditions. At the end of trainings, participants should be able to support a youth developing signs and symptoms of a mental health condition or an emotional crisis. They should know how to assess for risk, how to respond to youth, make connections to professionals, and encourage coping and self-help.

Mental health training initiatives seek to raise awareness of mental health signs and symptoms and provide information about where to go for help in the community. Youth Mental Health First Aid is a public education program that introduces community members to the unique risk factors and warning signs of mental health problems in youth. It also builds understanding of the importance of early intervention, and teaches people how to help youth in crisis or experiencing a mental health issue. The training discusses common mental health challenges, typical adolescent development, and provides resources to develop action plans for youth in crisis.⁴⁹

Ending the Silence is another training model, provided by affiliates of the National Alliance on Mental Illness (NAMI). Ending the Silence is a 50-minute mental health awareness program for high school age youth. Teens learn how to recognize the early warning signs of a mental health condition and what to do if they or someone they know is exhibiting these signs. Ending the Silence instills a message of hope and recovery and encourages teens to reduce stigma and end the silence surrounding mental health conditions.⁵⁰

Given this type of flexible model, it is important to ensure overarching goals are met across programs. The following guiding principles should be used in implementing this training program:

- Training needs are community-driven, focusing significantly on increasing knowledge of mental health, substance use, awareness around the pervasiveness of trauma, and stigma surrounding these conditions.
- Training is delivered by instructors with appropriate clinical expertise and who are trained in cultural competency.
- In addition to mental health and substance use, trainings address adolescent development and are trauma informed.
- Trainings raise awareness of racial disparities among mental health conditions and access to treatment.

3. Amend the Illinois Mental Health First Aid Training Act

We propose amending Illinois Public Act 098-0195, the Illinois Mental Health First Aid Training Act, 405 ILCS 105/1., to incorporate these goals and provide sufficient funding to implement trainings across the state.

Funding

Illinois currently has a law on the books (P.A. 098-0195) that allows the Illinois Department of Human Services to support training grants for Illinois Mental Health First Aid training, but is subject to appropriations. Pending federal legislation, the Mental Health First Aid Act of 2015 (S. 711/H.R. 1877), would authorize \$20 million for Mental Health First Aid, and seeks to institutionalize funding for such trainings in the long term. If such funding became available, federal funding could be used to support MHFA training, with additional investment from appropriation or a private sector partnership, needed to cover the other training models. Illinois should support federal legislation such as the Mental Health First Aid Act of 2015 as an opportunity for funding for these efforts.

B. Law Enforcement and Initial Detention

While community diversion should be Illinois' priority, the reality is that years of inadequate funding and disinvestment in Illinois' mental health system has left law enforcement all too often as first responders, and jails as new dumping grounds for youth with mental health conditions. Of the nearly 30,000 youth arrests and 11,000 youth admissions to local jails in Illinois each year, research consistently suggests that approximately 70 percent meet the diagnostic criteria for having a mental health condition, and at least 20 percent live with serious mental health condition, such as schizophrenia, bipolar disorder, and major depression, and other conditions that severely impair their ability to function.^{51, 52, 53} A majority of the youth, about 75 percent, who are arrested with a mental health condition are not involved in violent crimes, but mainly are arrested for property offenses and probation or parole violations.⁵⁴ In fact, they are far more likely to be victims than perpetrators of a violent crime.⁵⁵

In Illinois, law enforcement traditionally has not been adequately trained to deal with youth with mental health conditions, and have limited information about diversion programs. As a result of the lack of training, officers may see the behavior of youth living with mental health conditions as intentional, when it may in actuality be related to their mental health condition. This leads to their arrest, removal from community support, increased isolation and furthering traumatization—all of which may exacerbate their mental health conditions.

Following initial contact with law enforcement, whether a youth is screened for a mental health condition or receives treatment is often based on which police officer they've encountered or to which police station they have been taken. Some law enforcement officers and police stations provide mental health screening or have relationships with mental health providers to facilitate effective diversion (such as CCBYS); others do not. Further, the diversion programs that do exist often come with a station adjustment, where the youth may receive treatment but will also be marked with a criminal arrest record.

But for many youth, their first mental health screening or treatment occurs once they are locked in the jail. Often mental health services are non-existent in youth jails, or the services provided are inadequate because of insufficient funding, resources, and trained staff.⁵⁶ These facilities were not designed to provide this type of mental health care, and the services youth do receive are often ineffective and insufficient to meet the youth' needs. Research shows that one-third of incarcerated youth are diagnosed with depression, and the onset of depression occurred after they were locked up.⁵⁷ Youth with mental health conditions get worse in jail, not better.

For these reasons, the Task Force makes the following recommendations for law enforcement and jails to divert youth living with mental health conditions.

RECOMMENDATION 5: Expand Crisis Intervention Team Training for Youth (CIT-Y)

Background

The Crisis Intervention Team (CIT) model, developed in Memphis in the late 1980s, is designed to improve the outcomes of interactions between law enforcement and individuals living with mental illness. CIT is a voluntary 40-hour training that relies on community collaboration and individual and family involvement in training law enforcement to de-escalate mental health emergencies. CIT officers seek to divert individuals to appropriate mental health services or emergency rooms for treatment, as opposed to criminal involvement. CIT is not just a training program, as it also relies on the collaboration of community mental health partners, law enforcement agencies, families and individuals with lived experience, and other stakeholders to be successful. The original model of CIT was based on interactions with adults. Advanced training has

75%

of youth arrested who have a mental health condition are arrested for nonviolent crimes such as property offenses and probation or parole violations.

been developed in Chicago, with the support of the Illinois Law Enforcement Training and Standards Board (Board) and others, to focus on interactions with youth and young adults. Common principles for the CIT-Y programs include:

- Community Partnerships
- Needs Assessment
- Planning
- Oversight and Feedback
- Training
- Involvement of Youth and Families
- Outcomes Research

A white paper developed by the Nation Alliance on Mental Illness (NAMI) identified several positive outcomes from programs being developed in Colorado, Illinois, and Texas.⁵⁸ These programs:

- Reduced the need for the use of force in a crisis, thereby reducing the trauma experienced by police officers who injure youth and improving the safety of law enforcement personnel.
- Provided a proactive approach to preventing crises in schools.
- Linked youth with mental health conditions to services in the community, and reduced the need for treatment in more costly and restrictive settings.
- Reduced the lag time between the first onset of mental health symptoms and when an intervention was provided.

Additionally, evaluation of the Chicago CIT-Y program concluded that CIT-Y trained officers had an increased knowledge and more favorable attitudes toward handling youth crisis service calls. Officers were also very satisfied with the training curriculum. However, some barriers to continued implementation of the program existed, including lack of program awareness among the department and public, lack of department support, difficulties with dispatcher linkage to calls, unavailability of non-emergency community based treatment providers besides psychiatric hospital admission, and difficulty in accessing department paperwork to document the event.⁵⁹

For some of these reasons, in addition to a shift in direction within the Chicago Police Department (CPD), CIT-Y has not been prioritized in recent years. However, it is expected that CPD will offer this advanced training in 2018.

Generally, training in Illinois is facilitated by the Illinois Law Enforcement Training and Standards Board. Training is conducted through mobile training units and is based on the needs of local areas identified through a needs assessment process. At this time, there are no other CIT-Y programs across the state. The Board is expected to develop a standardized three-day CIT-Y program by the end of fiscal year 2018. Once the program is developed, any instructors providing CIT-Y will need to be approved by the Board, and content must meet or exceed the standards for the course that the Board has approved.

Changes Needed

1. Incentivize Local Juvenile Justice Councils, Redeploy Boards, and Other Juvenile Justice Stakeholder Groups to Create Steering Committees for the Implementation of CIT-Y Programs.

A crucial component of CIT-Y is the creation of a stakeholder steering committee to guide collaboration among stakeholders and ensure program sustainability as individual members change over time. Stakeholder groups include agencies involved with the juvenile justice system, mental health providers, mental health advocacy groups, youth serving hospitals, and schools. There are many groups in Illinois that already focus their work on juvenile justice diversion and the specific needs of the youth in their communities. We recommend these stakeholder groups collaborate with local law enforcement to bring the CIT-Y model to their communities (where models don't already exist), with the support of the Board. Establishing CIT-Y steering committees or advisory groups based on existing collaborations will help ensure implementation on an ongoing basis.

2. Expand Availability of CIT-Y Trainings Across the State.

The Board is responsible for providing CIT training and certifying CIT courses provided across the state. To complete a CIT-Y advanced training, an officer must first be trained through the basic CIT program. Basic CIT trainings are held regularly. Once developed and approved by the Board, local law enforcement agencies should request CIT-Y training through their annual needs assessment survey conducted by the Board mobile training units. This is the primary way the state determines law enforcement training needs, and should be utilized in expanding availability. Additionally, there is a new requirement that law enforcement officers have mental health training every three years (IL PA 100-024) and CIT-Y training should count toward the basic requirement as another avenue to incentivize and expand this training model.

3. Ensure CITY-Y Programs are Robust and Include all Necessary Components.

In addition to the crucial role training plays in the CIT-Y program, community collaboration, evaluation, maintaining relevant information and the involvement of youth and families are key components to ensuring a robust program with positive outcomes. We recommend developing technical assistance opportunities for stakeholder groups and law enforcement agencies to support the progression of CIT-Y programs. This may include assisting with strategies to engage schools, community mental health providers, and the new systems necessary to improve the overall program, like developing a checklist that outlines protocol for officers dropping youth off at a hospital. This should also include maintaining up-to-date information on Illinois laws and best-practices related to law enforcement interactions with youth living with mental health conditions.

Ensuring that local 911 call takers are trained on the availability of CIT-Y trained officers (or other specially trained officers) is an important component of a robust CIT-Y program. Linkage to an appropriate officer during mental health emergencies is key to ensuring a response that is based on specialized training. The information collected and provided to law enforcement

should be standardized by local municipalities to ensure that officers have the information necessary to respond. This includes appropriately identifying the attributes of officers (whether they are CIT/CIT-Y trained), historical information on the residence calling with the emergency, and mental health related information provided to the 911 call taker. Both the collection of this information and the availability of it for officers plays a large role in the response. As the Board develops the dispatch mental health awareness curriculum (CIT for Dispatch) for roll-out across the state, these components should be included. This will ensure that dispatchers are familiar with all the resources related to CIT available in the community.

4. Train School Resource Officers (or Other Officers Stationed in Schools) in Mental Health.

Youth spend a large portion of their time in the school setting, and research shows that “the environment surrounding where children live and the experiences they bring with them into the classroom greatly affect their learning once they enter the schoolhouse doors.”⁶⁰ What youth are experiencing at home also impacts their behavior. For this reason, “schools offer an ideal context for prevention, intervention, positive development, and regular communication between school and families. School health and student support services are critical components of a comprehensive approach to safe and successful schools.”⁶¹ In recent years, officers stationed in schools have become responsible for addressing address “minor disciplinary infractions such as talking back to teachers, truancy, horseplay, uniform violations or other disobedient behaviors.”⁶² This reiterates the importance of training for School Resource Officers so they can identify and appropriately respond to symptoms of trauma and mental health needs.

The Board has recently developed an introductory course on mental health awareness for law enforcement. This training can be used by municipalities as a baseline for School Resource Officers, security officers in schools, and other officers stationed in schools, with additional mental health training provided through CIT-Y in areas where a CIT-Y program exists, and the officers are eligible.

5. Standardize Tracking CITY-Y Officer Interactions With Youth to Evaluate the Program.

Given that CIT-Y programs are not currently pervasive across the state, a standardized report for interaction with youth by CIT-Y officers does not exist. However, consistent information regarding interaction with youth living with mental health conditions will help this program more successfully interact with the target populations. In conjunction with other diversion programs, local municipalities with CIT-Y programs should develop a standard approach to data collection that, at a minimum, includes the disposition of the interaction, whether any linkage to mental health providers was made and identifies gaps within the CIT-Y program. This information is crucial to understanding CIT-Y as a diversion program and as a basis for program evaluation. Evaluations should be a required component of CIT-Y implementation and findings should be reported at the aggregate level and made publicly available.

6. Increase Awareness of Mental Health Conditions and Youth Development Among All Officers

With the decline in community based mental health resources, police officers across the state have become the safety net during mental health emergencies. This is stressful for officers - who may have very limited training in mental health - and for individuals and families that must turn to police for a medical crisis. While a more appropriate response is needed, law enforcement currently need more information about mental health conditions and effective emergency response. Raising the baseline knowledge of all officers, through recruit training or otherwise, would assist in increasing comfort among officers during mental health emergencies, and help officers appropriately identify youth experiencing mental health condition and assist in diversion and referral. Further, any officer may interact with youth before the deployment of a juvenile officer, and therefore should have an understanding of adolescent development and typical youth behavior. For these reasons, training in police academies should be examined to ensure recruits receive adequate and effective mental health training. Training should be scenario based and focus on identifying red flags so officers are not starting at a deficit out of the academy. They should also be monitored and evaluated on an ongoing basis to ensure effectiveness. Additionally,

officers interested in specialized training and eligible for basic CIT can volunteer to participate and built additional skills that assist in diversion.

Funding

Law enforcement training provided through the Illinois Law Enforcement Training and Standards Board is funded through the state based Traffic and Criminal Conviction Surcharge Fund. Training programs mentioned above, if coordinated through the mobile training units, fall under this category. Federal funds for crisis intervention teams are provided through the Edward Byrne Memorial Justice Assistance Grant (JAG) Program.⁶³ In FY16, Dixon Police Department and Naperville Police Department received JAG funding for diversion programs.⁶⁴ Federal statute was amended through the 21st Century Cures Act of 2016 to include police crisis intervention teams (Section 14001).⁶⁵

While funding for training and building CIT programs continues to be incentivized through the streams mentioned above, funding for program evaluation is typically not included. This is a major gap in understanding the impact of such programs. Alternate funding through local municipalities or private partners might be needed to ensure these activities are implemented.

RECOMMENDATION 6: Avoid the Use of Arrests for Misdemeanor Offenses Committed by Youth Living with Mental Health Conditions.

Background

For youth who encounter the juvenile justice system, the impact of an arrest, let alone a conviction, can be significant. Justice involvement can create challenges engaging in school, getting a job, securing housing, and can negatively impact family relationships. These are the realities for youth who interact with the justice system, whether it is a result of untreated mental health conditions, or other reasons.

In the last twenty years, after a shift in perspective regarding the juvenile justice system asserting that the system was too light on crime, “information sharing about adjudicated juveniles has become easy and encouraged, and rules surrounding youth

privacy and confidentiality have loosened in the interest of public safety.”⁶⁶ The problem being that “the lack of discretion with which sensitive information is shared outweighs this usefulness.”⁶⁷ For example, school settings “have been granted unparalleled power to access juvenile records and impose new disciplines that involve law enforcement, arrests, convictions, and the possibility of a record.”⁶⁸

Protecting youth from unintended consequences of involvement with the justice system is imperative in ensuring they can thrive in their communities. This is one of the reasons to consider when and whether arresting a youth is warranted.

In states like Florida and Delaware, the introduction of non-monetary civil citations in lieu of an arrest has shown great benefits to youth. These states have formalized processes for law enforcement to provide a civil citation, avoid arrests for non-serious misdemeanor offenses, and connect youth to services through an assessment center model or otherwise for a variety of needs, including but not limited to mental health services. Particularly in Florida, with significant emphasis on transparency and reporting, the effectiveness of this type of program is clear.

Florida’s civil citation program is authorized by Florida State Statute 985.12, which provides law enforcement with an alternative to arrest for youth who commit first-time, non-serious delinquent acts.⁶⁹ In addition to the eligibility criteria, legislative requirements of the civil citation program include statewide implementation at the local level, assessment of needs of the youth, and reporting youth data to the Florida Department of Juvenile Justice for tracking and analysis. This shift occurred to keep youth who pose no real threats to public safety out of the justice system without an arrest record established, reduce costs of processing youth for misdemeanors, and free up limited resources for law enforcement to focus on more serious and violent offenders. As of July 2017, 61 of Florida’s 67 counties had an active civil citation program.⁷⁰

A review of Florida’s program shows that youth who received a civil citation recidivate less than eligible youth who were arrested and diverted,⁷¹ and overall, just 5% of youth who received a civil citation recidivate, which is the lowest

recidivism rate of programs tracked by the Florida Department of Juvenile Justice.⁷² Florida has examined whether the implementation of the civil citation program has created a net-widening effect, and found through research funded by the National Institute of Justice that no significant net-widening has occurred. This evidenced by discovering that there was no significant change in the trend for civil citation juveniles after implementation as well as a significant decrease in the trend for the first-offender misdemeanor juvenile population.⁷³

Delaware also utilizes a statewide model of civil citations. The program is an alternative to a formal arrest and criminal prosecution of youth for certain low-level misdemeanor offenses. The main goals of the program are to prevent further justice involvement for the youth and to appropriately address the youth’s offense without creating a criminal record. The program offers law enforcement the option of issuing the youth a civil citation in lieu of an arrest and requires that the youth participate in an assessment and subsequent services through a community based provider, among other stipulations.⁷⁴ Since the inception of the program in 2015, over 350 youth have been referred through a civil citation with 86% completing the terms of their citation.⁷⁵

The alternative to formal processing that is typically used in Illinois is an informal or formal station adjustment, but even an informal station adjustment creates an arrest record and Class A and B misdemeanor arrests of juveniles may be reported to the state police (705 ILCS 405/5-301; 20 ILCS 2630/5).

Changes Needed

1. Pilot a Diversion Program That Avoids the Use of Arrest

Illinois should implement a diversion program that avoids the use of arrest for misdemeanor offenses committed by youth living with mental health conditions. While Florida and Delaware do not limit their populations for this program, this serves as a starting point for the conversation in Illinois. This change affords youth the opportunity to engage in services as needed, and avoid the impact of an arrest on their record. Whereas the use of informal or formal station adjustments in Illinois does not always provide incentive for youth to complete the terms required, youth who avoid arrest at the onset of interaction with

law enforcement are now given the incentive to be accountable for engagement in programming and avoiding arrest completely. This also is an opportunity for family engagement and accountability in meeting the terms of the program.

Illinois should consider a pilot, non-monetary civil citation or otherwise, that would allow for eventual statewide roll-out, and provide technical assistance and training through a coordinated state agency. Tracking and evaluation in a database separate from centralized arrest records already collected in Illinois is a critical component of such a program. In Florida, this is done through the juvenile offender information system (JJIS) Prevention Web at the Department of Juvenile Justice. This is a separate part of the information system and data entered in the Prevention Web is not shared with outside agencies without specific approval.⁷⁶ While information sharing with law enforcement agencies may be needed, how much information is shared, and the implications on the use of information should be carefully considered. Further, data collection should consider the goals of evaluation, which should include at a minimum: demographics (age, race and gender), offense, disposition, recidivism, location of encounter (school vs. community), services provided, engagement in services, and longer-term (2+ years) positive outcomes such as educational or vocational engagement.

Funding

In Florida, the civil citation utilizes community based services already available through their Department of Support Services and investment by the state. Typical processing of a juvenile in the Florida system costs \$5,000. The cost of processing a youth through the civil citation program is \$386, a savings of \$4,614 per youth, which has saved the state more than \$50 million since 2007.⁷⁷ The civil citation program in Delaware is funded by the US Bureau of Justice Assistance, as well as by the state.

RECOMMENDATION 7: Implement Best Practices of Juvenile Assessment Center Model

Background

The Juvenile Assessment Center (JAC) model was born in Miami, Florida out of a need to more quickly process youth who were arrested at a time when juvenile arrests were climbing. In the mid-1990s, the legislature in Florida created juvenile assessment centers with the intent of co-locating agencies that interface with youth.⁷⁸ The Miami-Dade model was developed in partnership with several juvenile justice stakeholders and opened in 1997. Since the initial inception, when the JAC was funded by the Miami-Dade Police Department and the Florida Department of Juvenile Justice, the JAC has transitioned to the Juvenile Services Department (JSD) and is its own county department.⁷⁹

The Miami-Dade model is recognized as a best practice in juvenile assessment centers due to its rigorous evaluation, transparency and its reduction in juvenile arrests. The Miami-Dade model began as a National Demonstration Project.⁸⁰ While connection and linkage to service is a primary component of the Miami-Dade model, underlying principles include:

1. Avoiding arrest
2. Transparency in data
3. Inclusion of stakeholders in an advisory capacity.

This model “allows representatives from law enforcement and social services to work together under one roof to provide a complete range of services and programs at the initial stages of the juvenile’s involvement with the Juvenile Justice System.”⁸¹ There are four components to the JSD services:

- **Intake and Screening:** children who are taken into custody by the police are delivered to the JAC for screening and intake processing
- **Diversion Services:** graduated interventions based on the psychosocial assessment, the age of the youth, the alleged offense and its impact on the victim or community, and the youth’s history within the system. One of these interventions is the Civil Citation Program (as described in the previous recommendation). The impact of civil citations is rigorously and publicly measured and evaluated.⁸²

- **Prevention:** address the issues of the at-risk population to prevent their entrance into the juvenile justice system using empirically based screening and assessment tools designed and administered in an appropriate manner
- **Clinical Unit:** provides appropriate interventions for children in crisis and clinical assistance when dealing with youth exhibiting severe mental health and substance abuse issues.

A significant amount of data is released and reported by JSD and includes the percentage of citations versus arrests, the racial breakdown of youth encountered, where the encounter originates from, recidivism, offense, disposition and other indicators.⁸³ The data shows reductions in juvenile arrests, reductions in use of detention, and significant cost savings.⁸⁴

In Chicago, a juvenile assessment center was developed in the early 2000s by the Mayor's Office, the Chicago Department of Family Support Services and the Chicago Police Department. Chicago's entity is called the Juvenile Intervention and Support Center (JISC). The JISC was established through interagency partnerships to provide prevention and intervention services for youth arrested for low level misdemeanor offenses. The model utilizes case management and supportive services for charged youth, ages 10 - 16 years, and 17 years olds who have been charged with misdemeanors only, in a subset of Chicago police districts. The Chicago JISC differs substantially from Miami-Dade in that it:

1. Relies on arrest for lower level offenses as opposed to civil citation
2. Limits public reporting of aggregate data on the operation of the JISC
3. Limits involvement of community providers or youth in the design, operation and data management of the juvenile center.

Changes Needed

1. Key components of a best practice Juvenile Assessment Center model should be included in all models developed in Illinois.

The Juvenile Assessment Center model represents an opportunity to co-locate and integrate services that are readily usable by law enforcement in the event of a diversion (station adjustment or otherwise). This formal relationship between law enforcement, case management, and social service agencies is based on the collaboration among many juvenile justice partners and community-based stakeholders. We recommend the implementation of the best practice of this model as a diversion program to expand in Illinois, with the inclusion of the following core components:

- Provide linkage to case management and evidence-based services provided by community partners as indicated on a validated assessment.
- Reduce reliance on formal processing and end arrest records using civil citations as an alternative (see Recommendation #6).
- Require the reporting of measures including the percentage of arrests vs. adjustments (or other means), demographics (including age, race and gender), offense, disposition, recidivism, location of encounter (school vs. community), services provided, engagement in services, and longer-term (2+ years) positive outcomes such as engagement in services and educational or vocational engagement, among others.
- Include a formal advisory body of juvenile justice stakeholders, community partners, youth and their families.
- Provide an annual report on the operation, evaluation, and outcomes from juvenile assessment centers as to their stated goals. This report should examine a wide range of issues, including ensuring that juvenile assessment centers do not result in net-widening, reduce racial disparities in arrest practices, and ensure public safety in overall reductions of juvenile arrests.

2. Include transparency of program outcomes as a requirement for funding a juvenile assessment center model to ensure that the model is producing outcomes in line with objectives.

Transparency in data collection and reporting is fundamental to understanding how a program like the juvenile assessment center meets the objectives set forth by all stakeholders and community partners. This is where we see how the juvenile justice system interacts with youth and ensure these processes aligns with our stated guiding principles. Ensuring transparency as a requirement of funding creates a more open environment while also ensuring that expected outcomes are being met.

Funding

Juvenile assessment center programs are most frequently funded through a combination of federal, state, and local funds.^{85, 86, 87, 88} In at least one instance, an assessment center was able to fund its programs with resources from a Community Service Block Grant.⁸⁹ In another instance, the staff of a center was funded through local and recreation budgets.⁹⁰ Other creative funding arrangements have included private grants and in donations of space and equipment from community-based agencies.⁹¹

In Illinois, the state Department of Human Services funds community alternatives to juvenile incarceration through Redeploy Illinois. The Redeploy model involves grants to counties that pledge to reduce juvenile incarceration by 25%, and urges the use of evidence-based programming but allows substantial county independence in selecting programs to fund. Transparency is assured through the requirement of regular reports on the use and outcomes from funding, and an annual report to the legislature ensures overall program accountability. A relatively modest state investment (\$4.8 million annually or less) in Redeploy has resulted in dramatic savings, with the state closing three juvenile prisons due to the reduction in commitments. A similar state funding model could work equally well at the front end to ensure diversion with services to avoid arrest records and to address local service needs.

RECOMMENDATION 8: Evaluate Effectiveness of Station Adjustments for Juvenile Offenses

Background

Formal and informal station adjustments can be used as a diversion tool to avoid referring a youth to further involvement with the juvenile justice system. Illinois code 705 ILCS 405/5-301 describes both formal and informal station adjustments, and it gives discretion to a juvenile police officer in deciding when to impose a station adjustment based on the following criteria:

- a) The seriousness of the alleged offense
- b) The prior history of delinquency of the youth
- c) The age of the youth
- d) The culpability of the youth in committing the crime
- e) Whether the offense was committed in an aggressive or premeditated manner
- f) Whether the youth used or possessed a deadly weapon when committing the alleged offenses

An informal station adjustment can be used when a juvenile police officer determines that there is probable cause to believe that the youth has committed an offense. Conditions for an informal station adjustment may include:

- a) Curfew
- b) Conditions restricting entry into designated geographical areas
- c) No contact with specified persons
- d) School attendance
- e) Performing up to 25 hours of community service work
- f) Community mediation
- g) Teen court or a peer court
- h) Restitution limited to 90 days

If the youth does not abide by the conditions of an informal station adjustment, the juvenile police officer may impose a formal station adjustment or refer to the State's Attorney's Office.

A formal station adjustment can be used when a juvenile police officer determines that there is probable cause to believe the youth has committed an offense and there is an admission by the youth of involvement in the offense. The youth and parent or guardian must agree in writing to the formal station adjustment, and must be advised of the consequences of violating the agreement.

Conditions of the formal station adjustment may include:

- a) Length of 120 days or less
- b) Not violating any laws
- c) Attending school
- d) Abiding by a set curfew
- e) Payment of restitution
- f) Refraining from possessing a firearm or other weapon
- g) Reporting to a police officer at designated times and places, including reporting and verification that the youth is at home at designated hours
- h) Performing up to 25 hours of community service work
- i) Refraining from entering designated geographical areas
- j) Participating in community mediation
- k) Participating in teen court or peer court
- l) Refraining from contact with specified persons

A formal or informal station adjustment does not constitute a young person being found guilty or a criminal conviction. A youth or his or her parents or guardians may refuse a formal station adjustment and have the matter referred to court or other action and can also revoke consent within 30 days.

If the youth violates any term or condition of the formal station adjustment, the juvenile police officer provides written notice of violation to the youth and the youth's parent or guardian. The juvenile police officer may take any of the following steps from that point:

- a) Warn the youth of consequences of continued violations and then continue the formal station adjustment
- b) Extend the period of the formal station adjustment up to a total of 180 days

- c) Extend the hours of community service work up to a total of 40 hours
- d) Terminate the formal station adjustment unsatisfactorily and take no other action
- e) Terminate the formal station adjustment unsatisfactorily and refer the matter to the State's Attorney

There are limitations on the use of a formal or informal station adjustment, including the number of adjustments that are allowed over a period.⁹²

In Illinois, law enforcement officials are required to submit arrest fingerprint cards for all juveniles over 10 who have been arrested for an offense which would be a felony if committed by an adult. Law enforcement has discretion and may submit arrest fingerprint cards for youth arrested for Class A and B misdemeanors.⁹³ Based on the Juvenile Justice Reform Act, established in the late 1990s, the Illinois State Police was given authority to create a juvenile criminal history system, which is similar in concept and scope to the adult system.

Juvenile arrest cards that are reported to the Illinois State Police include the ability to report station adjustments, probation adjustments, filing decisions, and disposition and sentencing information in the same document. The arrest cards also include fingerprints, which are then compiled with the criminal history through an electronic infrastructure in real time.

There are many components to the arrest card that collect information on the youth, including: demographic information, descriptive information, arrest disposition, and offense. There is a section to indicate if the offense was related to domestic violence. No direct information is collected about mental health status.

Challenges to the reporting and evaluating data collected by the Illinois State Police prevent a full picture of how station adjustments are being used across the state. Two barriers to complete juvenile records are the limiting of mandated reporting to juvenile felony events and the providing of discretionary reporting of misdemeanors. Both create opportunities for missing information. "The key to each criminal history event is the arrest information, submitted with the youth's fingerprints. Case outcome information cannot

be posted to the Criminal History Record Information (CHRI) system unless the corresponding fingerprint based arrest record has been submitted...research on discretionary juvenile arrest submission policies and practices would require a review of local juvenile arrest and court records.”⁹⁴

Only a fraction of juvenile arrests is reported to the Illinois State Police, and only a fraction of diversions (listed as station adjustments) are included in that total. The purpose of the data collection is for the use of law enforcement and hinges on a fingerprint record. Relying on the information collected through the central database is not the best avenue for assessing the use of station adjustments, as it perpetuates the youth’s record.

Changes Needed

1. Develop a Pilot To Evaluate How Station Adjustments Are Used As Diversion

It has become clear to the Task Force that significant challenges exist in understanding the use of station adjustment in Illinois. As tool for diversion available to all juvenile officers, we have no real sense of how they are being used and where. This is a first step in understanding the value of station adjustments and of the services available to youth. One of the practical challenges is that the central collection agency for information around station adjustments is the Illinois State Police, which uses this information for the purpose of law enforcement and relies on fingerprinting. We want to better assess the use of station adjustments, but not at the expense of creating additional juvenile records.

We recommend developing a pilot project that focuses on a manageable geographic area and creates a system—separate from law enforcement purposes—that collects aggregate information on all station adjustments performed, including age, demographics, where the youth lives, what was offered under the station adjustment, and the final disposition. Using this information as a baseline, we can: 1) develop an approach to data collection statewide and 2) use this information to inform best practices around connection to mental health services via a station adjustment.

Funding

This pilot project is an effort to better understand a current diversion tool used in Illinois. Several juvenile justice system partners might find this within the scope of their work, including the Illinois Criminal Justice Information Authority, as the Authority has done research around the Criminal History Record Information system and the Illinois Juvenile Justice Commission. The Juvenile Justice Commission funds the Juvenile Management Information System (JMIS), which is the statewide repository of juvenile detention data at the Center for Prevention, Research, and Development (CPRD) at the University of Illinois. A data collection and analysis project of this type might be similarly of interest to these entities.

C. Courts

Whether a young person is detained awaiting trial or released in advance of a trial, the petition of delinquency filed by the state's attorney starts the formal juvenile court process. New information may still influence the state's attorney to dismiss the petition, enter a plea agreement, or refer the youth to a diversion program. However, a young person proceeds with the court process if he or she has pled not guilty, has not been diverted, did not sign a plea agreement, and there are still charges against him or her. Even at the point of a trial, there are options for diversion, such as restorative programming or court supervision. In 2016, over 3,600 cases against juveniles were filed in Cook County, with 800 resulting in supervision, 357 resulting in a trial, and over 2,300 resulting in a guilty plea.⁹⁵

If a young person is adjudicated delinquent, that is, found guilty, there are several options for sentencing. Probation is the most common sentence, and might include attending school or work, or engaging in counseling. This is done under the supervision of a probation officer who monitors progress. Intensive probation supervision may be required for youth under stricter supervision requirements. Conditional discharge might be used for youth with court mandates without the supervision of a probation officer. Youth may also be sentenced to treatment in a residential facility, although this is typically a component of probation rather than the sentence itself. Home confinement or electronic monitoring can be used as well. The most restrictive sentences are jail in a detention center for short-term, secure confinement, or incarceration in an Illinois Youth Center operated by the Illinois Department of Juvenile Justice.⁹⁶

For youth living with mental health conditions, the rehabilitative goals of the juvenile court provide an opportunity to connect youth to services. Diversion continues to be an option up to the point of finding a young person guilty, and in principle the sentences that youth receive may include some form of mental health or substance use treatment. Problem-solving courts have emerged in the adult system to address underlying causes of criminal behavior through service provision at this point of the justice system. As juvenile courts further assess the needs of the youth they process, it is likely they'll find

extensive mental health needs within their populations.

The utilization of a mental health court model for juveniles

allows for the additional support required to address

these needs. One distinction from typical juvenile justice proceedings is the involvement of the family unit. The Task Force focused on juvenile mental health courts at this intercept point because of the national landscape where these courts are emerging, the growing use of problem-solving courts for adults in Illinois, and the anticipated national and Illinois based standards for juvenile problem-solving courts.

Therefore, the Task Force makes the following court recommendations for diverting youth living with mental health conditions.

RECOMMENDATION 9: Expand the Implementation of Juvenile Mental Health Courts in Illinois.

Background

Mental health courts seek to reduce recidivism by connecting defendants experiencing mental illness to supportive services and appropriate treatment as an alternative to incarceration.⁹⁷ Like other problem-solving courts, mental health courts look beyond individual charges to address underlying issues that contribute to criminal behavior. While focusing on mental health, other issues like employment and stable housing are addressed to prevent future crimes by supporting the individual.

Mental health courts focus on the concept of therapeutic jurisprudence, which guides the court not only to look backward by finding fault and imposing punishment, but also to look forward to the participant's reentry into their community, and the associating benefits of successful reentry.⁹⁸ The court responds "to crime by seeking to rehabilitate the offender and

In 2016, over

3,600

cases against juveniles were filed

in Cook County.

repair the harm suffered by the victim and community rather than by punishing the offender according to retributive or deterrent principles.”⁹⁹

Nationally, there are over 400 adult mental health courts, with 30 operating in Illinois. Evaluations have demonstrated success among mental health courts, showing “lower recidivism among mental health court participants during and after participation compared to those with mental health issues in traditional court processes”.¹⁰⁰

Juvenile mental health courts are beginning to emerge as well. The first juvenile mental health court was established in Santa Clara County, California in 2001.¹⁰¹ While the juvenile mental health courts are similar in nature to adult mental health courts, there are important distinctions. Juvenile mental health courts must be age-appropriate and understand the variations in juvenile development and maturity. The youth’s success in juvenile mental health court relies both on their compliance with program requirements and their guardian’s cooperation, meaning that “one major distinction of [juvenile mental health courts] is that the network of accountability is much broader than in the adult system”.¹⁰² Other stakeholders, like families and schools, must be included in juvenile programs in addition to justice partners and providers.¹⁰³ Eligibility requirements vary from court to court. Generally a juvenile must be diagnosed with a serious mental health condition that is linked to their involvement in the court system; however some courts accept juveniles with less intensive conditions. Some courts only accept juveniles charged with low-level crimes, though requirements range widely and many courts accept juveniles charged with low-level felonies.

Research shows that juvenile mental health courts share the following common characteristics:¹⁰⁴

1. Regularly scheduled, specialized court docket
2. A style of interaction among court officials and participants that is less formal than traditional courts
3. Age-appropriate screening and assessments for trauma, substance use, and mental disorder
4. Team management of JMHC participant’s treatment and supervision
5. System-wide accountability enforced by the juvenile court
6. Use of graduated incentives and sanctions
7. Criteria for defining program success

Another early adopter was Alameda County, California, which established a juvenile mental health court in 2007 called the Alameda County Juvenile Collaborative Court. Researchers from the National Center for Youth Law reviewed the initial implementation of the Court and made recommendations for expansion and improvement. They found the Court to be a “promising model for a compassionate, safe, and effective intervention for youth with mental health needs who are involved with the juvenile justice system.”¹⁰⁵

In Illinois, the General Assembly passed the Mental Health Treatment Act of 2008 to authorize the creation of adult mental health courts in the state. While the legislation outlines three frameworks counties may implement—before a finding of guilt, after a finding of guilt, or a combination—there is no instruction provided for the most favorable or any specific requirements for a mental health court. This allows a county to tailor such a court to its specific needs.

In 2015, the Illinois Special Supreme Court Advisory Committee for Justice and Mental Health Planning released statewide standards for the certification of problem solving courts. These cover adult problem-solving courts, but the Youth Recovery Court in Winnebago (one of only two juvenile mental health courts identified) has used the standards as a guideline for setting up the court.

Changes Needed

1. Follow all standards for problem solving courts set forth by the Illinois Supreme Court Special Supreme Court Advisory Committee for Justice and Mental Health Planning.

In 2013, the Illinois Special Supreme Court Advisory Committee for Justice and Mental Health Planning was charged with developing uniform standards and a framework for an application and certification process for all Illinois problem-solving courts (PSC). The purpose of the statewide Standards is to provide “minimum requirements for the planning, establishment, certification, operation and evaluation of all PSC in Illinois”.¹⁰⁶ The Standards are based on evidence-based and

promising practices, “correlated with positive, cost-effective outcomes and enhanced public safety”.¹⁰⁷ While the Standards are statewide, they represent an opportunity for uniformity and consistency, while still allowing for local innovation. In the areas of the state where juvenile mental health courts are in operation, they have used the PSC Standards as guidelines for developing the courts.

2. Mental Health Courts developed for juveniles in Illinois should include a civil legal advocate on the core court team.

Illinois standards require that the problem-solving court team include a judge, a prosecutor, a public defender, probation officers, licensed treatment providers, and a local court coordinator. Teams may also include additional members, such as a participant’s private counsel of record. Based on the Collaborative Court model used in Alameda County, California, we recommend integrating a civil legal advocate for juvenile courts. The advocates can be “instrumental in addressing these unmet needs,” and courts that include such a role “can increase substantially the array of services and resources available to participating youth and their families.”¹⁰⁸ Such services can include providing legal assistance related to housing, consumer protection, or unemployment. Barriers to these services often impact the likelihood of the youth succeeding at home. Integrating these services directly into the team allow for additional support of the court model and can help contribute to long term success.¹⁰⁹

3. Juvenile Mental Health Courts should report outcomes to promote transparency and ensure racial and gender equity in program participants.

Based on research by the National Drug Court Institute, participation of African-Americans and Hispanic adults in Drug Courts was lower than their presence in arrestee, probation, and incarcerated populations. African-American and Hispanic participants also graduated at substantially lower rates than other Drug Court participants.¹¹⁰ While this is representative of a specific type of problem-solving court, and that of the adult system, it is imperative to ensure that with the implementation of juvenile mental health courts, the target population is

reflective of the populations impacted by the juvenile justice system. Reporting participant information will help increase transparency and monitor the impact of the court on youth.

4. Family involvement should be a core component of treatment planning for youth.

The Alameda County Collaborative Court maintains a core value that “young people are most effectively served in their homes and in conjunction with their families.”¹¹¹ They maintain that the “active participation and involvement of the youth and the youth’s family throughout the Collaborative Court process is essential to the youth’s successful transition back into the community.”¹¹² In order to ensure success, both the youth and his or her family must be engaged, supported, and at the center of collaboration. While time intensive, it is a core component because success relies on active participation in utilizing services and supports. Although this might be a different approach from adult mental health courts, this Task Force views family engagement as a factor for the successful diversion of youth and connection to services.

Funding

At the federal level, the Mental Health Courts Program is administered by the US Department of Justice Bureau of Justice Assistance (BJA) in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA). The program provides funds to communities which are investing in collaborative services for justice involved individuals living with mental health conditions. The goal of BJA’s Mental Health Court grant program is to decrease justice involvement by providing courts with resources to link individuals to services.

Federal funds have also been made available to the 17th Circuit Court of the State of Illinois in Winnebago County for the establishment of its juvenile mental health court, called the Youth Recovery Court. In 2011, it was awarded a three-year grant award of \$250,000 from the BJA and subsequent grant funding through the Illinois Criminal Justice Information Authority. Ongoing funding is still being identified. The approach to sustainable funding used in the Alameda County Juvenile Collaborative Court has been for partner agencies to each pay a portion of the costs to run the court.

D. Reentry

The days immediately after a youth is released from jail or prison are the most critical period for support. In 2017, the Illinois Department of Juvenile Justice reported that 95 percent of the youth in Illinois prisons have one or more mental health diagnosis. Returning youth with mental health conditions face a lack of community mental health providers, health care, job skills, education, and/or stable housing, all of which jeopardize their recovery and increase their probability of recidivism. Youth leaving jails and prisons often have lengthy waiting periods before attaining benefits or mental health treatment. Progress has been made in Illinois, which now restricts rather than terminates Medicaid benefits while youth are in jails and prisons. Yet post-release challenges remain. Waiting periods and the termination of benefits have devastating effects on the lives of youth who need to connect with mental health treatment providers to maximize the likelihood of recovery and prevent re-incarceration. Therefore, the Task Force makes the following recommendations for reentry of youth living with mental health conditions.

RECOMMENDATION 10: Expand Funding for Mental Health Juvenile Justice Initiative

Background

The Illinois Department of Human Services Division of Mental Health (IDHS/DMH) contracts with 20 community mental health agencies statewide to fund the Mental Health and Juvenile Justice Program (MHJJ). These agencies then fund MHJJ liaisons or clinicians to work with the juvenile courts in order to identify those youth who have a serious mental health condition. They then develop a community-based mental health action plan and establish linkages to necessary community supports for the youth and family.¹¹³ As a result, MHJJ fills a critical gap in services for county detention centers, which typically lack the clinical staff to provide mental health assessments and case management for youth in custody. The program is available statewide and to counties with youth detention centers. Under MHJJ, judges, attorneys, probation

officers, parents, and other juvenile justice stakeholders may also refer youth to the program.¹¹⁴

Upon referral, a MHJJ liaison screens the youth to assess eligibility for services.

Once eligible, then the liaison develops an action plan based on the youth's needs and strengths and links the youth with services within the community. These youth are tracked for a minimum of six months to assist with and facilitate their participation in services. Each year, this program serves approximately 300-400 youth and their families. A 2007 study showed that participants in the program had a 21.3 percent recidivism rate, compared with the state juvenile offender recidivism rate of 72 percent.¹¹⁵ This difference in effectiveness demonstrates that youth in the juvenile justice system living with mental health conditions can be identified and then connected with community treatment options that improve their clinical condition, increase their school attendance, and result in declines to re-arrest rates.¹¹⁶

In 2017,
95%

of youth in prisons had one or more
mental health diagnosis.

Changes Needed

1. Restore Flexible Funding

The state should restore the flexible funding for the MHJJ program. At its inception, the MHJJ program was supported by nearly \$1 million annually in General Revenue Funds (GRF) to cover the costs of community services for which providers were unable to bill Medicaid, such as transportation costs for youth to attend treatment and supports to help youth maintain residential stability. That funding was cut in FY14 and created a gap in the range of community linkages that youth and their families benefited from in order remain engaged in services. Since MHJJ is voluntary, the elimination of flexible funds has modestly impacted the youth and family incentives to participate.

2. Consistent Program Evaluation

In the past, the program has been evaluated by the Northwestern Feinberg School of Medicine's Mental Health Services & Policy Program. They quantified the program's successes and provided training and a web-based database for tracking youth progress. But following budget cuts in FY17, MHJJ has not been able to continue these program evaluation services and the web-based database used for tracking use has been offline. The inability to evaluate program effectiveness and monitor youth's progress in the MHJJ program compromises the ability for MHJJ to troubleshoot challenges and continuously demonstrate the effectiveness of their program.

Funding

The funding IDHS/DMH provides to community mental health agencies statewide for the MHJJ, which is then used to fund MHJJ liaisons or clinicians to work with the juvenile courts, has historically relied on GRF. The youth who are linked to services are usually eligible for Medicaid, and the agencies may bill Medicaid. Otherwise, there are rare instances where youth have private insurance. The funding for MHJJ has remained relatively flat over the last decade at 2.1 million, with approximately 17-20 agencies receiving funding annually. In FY18, the IDHS/DMH funded 20 agencies statewide.

RECOMMENDATION 11: Screen and Enroll Youth in Medicaid Before Reentry

Background

The Task Force recommends that youth who are incarcerated in Illinois' jails and prisons be screened for Medicaid and, if eligible, enrolled while in the facility. Illinois can ensure health care coverage upon release for thousands of youth with mental health needs. In FY2016, 3,371 youth were admitted to the juvenile detention center in Cook County, with an average stay of nearly one month,¹¹⁷ and 1,152 youth were admitted to IDJJ facilities throughout the state,¹¹⁸ with an average stay of 5 to 6 months.¹¹⁹

The importance of ensuring youth have health care coverage is magnified by their mental health needs. Nearly every youth

entering IDJJ receives a mental health screening within one hour of admission to facilities,¹²⁰ nearly all of whom are identified as having either mental health or substance abuse treatment needs.¹²¹ While the majority of these youth receive mental health services while incarcerated, research shows that ensuring these youth have health coverage can facilitate their integration back into their communities and reduce recidivism by bringing greater stability to their lives.¹²²

An increasing number of states have made efforts to enroll justice-involved adults in Medicaid plans following the passage of the Affordable Care Act (ACA) expansion. Some states are now also looking to ensure that justice-involved youth are enrolled in Medicaid as well, with the likelihood that nearly all are eligible. For many practitioners, this presents a tool for diversion, especially for youth with mental health needs.

Changes Needed

There is no federal statute, regulation, or policy that prevents individuals from applying for, being enrolled in, or being renewed for Medicaid while incarcerated. In April 2016 guidance, the Centers for Medicare and Medicaid Services (CMS) reiterated that incarcerated individuals may be determined eligible for Medicaid, and that the state Medicaid agency must accept applications and process renewals for incarcerated individuals.¹²³

Illinois law allows for incarcerated youth to apply for Medicaid while incarcerated and before the date of scheduled release.¹²⁴ Therefore, the Medicaid agency should have procedures in place to enroll and review incarcerated youth,¹²⁵ and juvenile justice agencies should cooperate with the enrollment process and the eligibility redetermination process.¹²⁶

Illinois also requires pre-release procedures for youth with mental health conditions, including an assessment for post-release treatment taking place three months before the scheduled release date.¹²⁷ This pre-release planning should include Medicaid enrollment, assignment to a Medicaid managed care plan, education about how to access and use health coverage under Medicaid, and a hand off of medical records to the primary care provider or mental health provider who will treat the youth upon reentry to the community.

The Task Force recommends a set of programs to support these existing policies to screen and enroll youth in Medicaid while either in detention centers or IDJJ facilities.

1. Incorporate Medicaid Identification into Intake Process

Illinois should include a Medicaid identification number in the intake process to track and utilize a youth's coverage. This number should be available to the records supervisor, health care administrator, and probation department. In addition, outside organizations such as the Sargent Shriver Center on Poverty Law and Get Covered Illinois may coordinate with the state to send navigators or certified application counselors to jails and prisons to help individuals enroll in Medicaid and provide technical assistance about how to integrate enrollment processes into facilities. The Task Force suggests Illinois consider practices from the following states:

- Oregon's juvenile justice agency pays the salary of a Medicaid eligibility specialist to determine eligibility and enroll youth.¹²⁸
- South Carolina and Wyoming share staff positions in the Medicaid and juvenile justice agencies to streamline the screening and enrollment.¹²⁹
- In Connecticut, the Department of Social Services provides two staff dedicated solely to processing Medicaid applications for individuals determined potentially eligible for assistance.¹³⁰

2. Incorporate Enrollment into Pre-Release Planning Activities

Coverage cannot begin until discharge from IDJJ, so youth who are not yet covered but eligible should apply for Medicaid when an anticipated release date is known and enroll before release. The Task Force also suggests Illinois consider practices from the following states:

- California requires juvenile justice agencies to notify the Medicaid agency about an inmate's release date, along with other information to help the agency determine eligibility. If inmates are found eligible, they are issued a Medicaid card immediately upon release. Expedited actions are required for inmates with disabilities.¹³¹

- In New Hampshire, state prison and county jail staff initiate Medicaid applications for individuals nearing release by using an automated processing or by completing and mailing all necessary forms to the Medicaid agency.¹³²
- Wisconsin allows inmates to apply for Medicaid over the month before their release. Coverage then goes into effect on the first

Funding

Under Medicaid regulations, federal funds are available to reimburse non-Medicaid government entities, such as IDJJ, for administrative costs related to identifying and enrolling potentially Medicaid-eligible youth.¹³³ Illinois also allows the Illinois Department of Healthcare and Family Services, in cooperation with IDJJ, to seek federal funds to support Medicaid eligibility and processing.¹³⁴

RECOMMENDATION 12: Alleviate the Medication Gap Upon Release From Jails and Prisons

Background

Continuity of care is crucial for youth living with mental health conditions when they are released from jail or prison. Without access to clinical services, their symptoms may worsen and their condition and functioning may deteriorate. Likewise, many youth are identified by the courts and probation services as possibly having mental illness, yet limited access to clinical services may delay these youth from obtaining further evaluation and treatment.

Many community based programs are overwhelmed and consequently have waiting lists. Wait time for services can take up to 90 days and, in some cases, agencies have stopped accepting new clients altogether. This presents a significant challenge to youth and their families who often receive 15 to 30 days worth of medication upon release. This potential lapse in treatment could place the youth at risk for other problems at home, school, and in the community and could ultimately increase the likelihood that the youth will re-offend.

While the ultimate fix to this problem would be to expand service capacity in the community, short-term solutions that are within the control of state and local agencies are recommended as a first step.

Changes Needed

1. Community-based mental health providers should prioritize youth leaving jails and prisons

While all youth suffering from mental illness should have access to psychiatric services in the community, priority access should be given to the highest risk youth. As stated earlier in this report, youth living with mental health conditions leaving jails and prisons represent one of the highest risk groups.

A system whereby community-based providers are offered incentives to give priority access to youths leaving juvenile justice facilities should be explored. Such a system would give these youth the ability to go to the top of the waiting list and access services sooner. The Mental Health Juvenile Justice (MHJJ) program offers such a service, whereby a youth who is referred to the program can access services at a MHJJ funded site without delay.

2. Allow prescriptions for a longer supply of medicine to youth living with mental health conditions before they are discharged.

When youth being treated with psychotropic medication are discharged from juvenile justice facilities, they are typically given a prescription or set amount of medication that will ideally last them until they are able to be seen by a psychiatrist in the community. Unfortunately, with long waiting lists to see providers in the community, many youth run out of medication before they are able to be seen.

It is recommended that a 30-day supply of psychotropic medications, at minimum, be provided at the time a youth is released. In some cases, it may be safe to prescribe more than a month's supply of medication to a youth that is well-known, demonstrated stability on the current medication, and has a follow-up appointment scheduled.

Clinicians may consider the following when determining prescriptions for youth being released from jails and prison facilities:

1. Whether the clinician is familiar with the youth? Whether the clinician has reason to believe the youth will be compliant with medication and return for the follow-up appointment?

2. Whether the clinician is familiar with the parents or guardians? Whether the clinician have reason to believe the parents will be able to monitor the medication?
3. Whether the youth is starting medication for the first time?
4. What type of medication?
5. Is there a risk of suicide?

3. When youth are unable to get community-based mental health services, allow them to return to the jail to get services through an outpatient clinic.

It is recommended that juvenile justice facilities explore the option of providing clinical services during the transitional “gap” for youths who have been placed on waiting lists for community services.

Several projects have demonstrated that detention based outpatient services can be effective. The HomeCare Program began in 2003 to facilitate psychiatric care for youths (ages 11–16) in the juvenile justice system who were leaving detention centers. The Department of Psychiatry at the University of Connecticut School of Medicine was awarded a grant to implement these services within the federally qualified health centers (FQHCs) in the state. The model, conceptualized as a “bridging service,” was developed on the premise that an advanced-practice nurse (APN) and a child psychiatrist would treat children and adolescents in the FQHC system, integrating care with child psychiatric staff in the FQHC environment. All referrals of juvenile justice children and adolescents come from probation or parole offices or the child welfare worker. The implicit goal of the HomeCare Program is referral to a longer-term provider.

The program was developed to provide a resource for detention-involved youths who require psychotropic medication as a condition of their release and return to the community. The program has received 900 referrals since 2003. About 17% are referred again for services after discharge from HomeCare. If other services do not work out, the clients return.¹³⁵

In 2013, The Cook County Juvenile Temporary Detention Center (JTDC) attempted to replicate the success of the HomeCare Program. The Bridge Program was launched as a pilot demonstration project with the goal of providing psychiatric

services, case management, family services, and individual counseling. In collaboration with Juvenile Probation and the JTDC, the Isaac Ray Center, Inc. operated The Bridge Program pilot from February 2013 to May 2014. The pilot project exclusively serviced youth who were re-entering the community after release from JTDC. Youth who participated in the pilot were seen by detention center providers who were familiar with the youth, and appointments were made on days that the youth already had court or probation appointments scheduled.

During the pilot, the program accepted 63 total referrals from the JTDC mental health department, the Juvenile Probation Department, and the Juvenile Court. Of these, 32 total cases were successfully linked with providers prior to first appointment in the clinic. The other 31 cases were provided with clinical services in the program and all but two cases were successfully discharged.

Evaluation of the 15-month pilot confirmed the critical need for services; it also demonstrated the essential elements to facilitate access to care and to maximize the opportunity for compliance with treatment recommendations. It was found that utilization of existing, facility-based resources can present a cost effective opportunity for youth to receive uninterrupted treatment during the difficult process of re-entry into resource poor communities.

Funding

The Task Force recommends that funding options for these kinds of projects be explored in the future.

RECOMMENDATION 13: Ensure Continuum of Services Upon Release From Jails and Prisons

Background

There are many services that need to be addressed, including but not limited to housing and income. It is common for justice-involved youth to experience housing instability or homelessness, increasing the risk of further justice system involvement. Many of these youth have significant histories of mental health and substance use conditions, two factors highly correlated with homelessness. Successful discharge planning helps to prepare youth for a smooth transition back into the

community. Housing instability and residential displacement for youth living with mental health conditions may still occur for reasons including physical or sexual abuse, neglect, substance use, and other barriers associated with their criminal history. Moreover, wait lists for rental assistance programs are long, and temporary and transitional housing are extremely limited. The Illinois Department of Human Services reports that 2,530 youth were turned away from temporary and transitional housing programs for homeless youth because of a lack of resources in 2015.¹³⁶

Stable income is another issue. Even upon leaving the Illinois Department of Juvenile Justice, the average age is 18 and youth will have increased financial responsibilities. These youth often find themselves without sufficient education, work experience, job training, or a credit history. Youth with well-documented histories of serious mental illnesses that inhibit their ability to work may be eligible for Supplemental Security Income (SSI) benefits, but they often need assistance securing these benefits.

Changes Needed

1. Provide Targeted Housing Assistance to Help Youth Living with Mental Health Conditions to Avoid Homelessness and Recidivism

Youth living with mental health conditions should receive targeted housing support, including rental subsidies or expanded temporary housing and housing assistance services. An example of a robust federal effort was the U.S. Department of Justice and the U.S. Department of Housing and Urban Development's Juvenile Re-entry Assistance Program (JRAP) in 2016, a program to reduce barriers to housing, jobs, and education for justice-involved youth and young adults up to age 24. The program provided \$1.75 million to Public Housing Authorities and non-profit legal service organizations to address the challenges justice-involved young people encounter when searching for work and a place to live. This funding included \$100,000 grants to both the Housing Authority of Cook County and the Chicago Housing Authority. This program could be modeled in Illinois to support organizations serving justice-involved youth at-risk of homelessness. Another program to consider is the Second Chance Act, passed through Congress

in 2008, to demonstration grants awarded to states for the development and implementation of juvenile re-entry assistance plans should inform our efforts to strengthen housing access and other re-entry supports for IDJJ-involved youth.

2. Begin the Supplemental Security Income Application Before Re-Entry to Prepare Youth with Serious Mental Health Conditions for Success in the Community

For youth with well-documented histories of significant mental health conditions who are likely to be eligible for SSI benefits, the State should enhance the SSI application process to ensure the best chance at successful reintegration. There are several opportunities for the State to improve connections to SSI for reentry youth with the most serious mental health conditions.

For example, for youth who received benefits prior to entering jails and prisons, SSI support should be initiated pre-release in accordance with the Social Security Administration's guidance on institutional release. For likely eligible youth who have not previously received benefits, facilities should facilitate the beginning of an SSI application as early as allowable under federal law prior to release. Under federal guidance, pre-release procedures and agreements can be established between correctional facilities and local social security offices to streamline the application process and expedite payment of benefits upon release. Facilities should establish pre-release agreements with social security offices accordingly.

Illinois could also provide funding to allow probation and parole to prepare expedited SSI applications, also known as known as SSI/SSDI Outreach, Access, and Recovery (SOAR) applications. These applications are fast-tracked applications for adults with behavioral health issues experiencing, or at-risk of, homelessness. This includes 17-year-olds who are within one month of their eighteenth birthday. For youth aging out of the child welfare system, SOAR applications may be filed within 90 days of their eighteenth birthday.

Pre-release planning should take place as early as possible and assess the unique needs of each youth. In order to ensure that youth are prepared for success at re-entry, planning should account for connections to a full range of services and supports, including SSI where appropriate.

For youth under the age of 18, the entity preparing their application needs to engage the youth's family to obtain household income, medical history, and other relevant information. It is recommended that jails and prisons work with an expert entity in collecting evidence and preparing SSI applications to ensure best outcomes. The Illinois Department of Children and Family Services, for example, contracts with an external entity in preparing SSI applications for youth in the child welfare system. The Wisconsin Department of Corrections even established a re-entry initiative employing attorneys to prepare Medicaid and SSI applications pre-release.

It should be noted that youth 18 and over should consider General Assistance Programs, especially because not all youth with mental health conditions will be able to meet the Social Security Administration's definition of being "disabled" and will still need a source of income until they can earn money. For these youth who are not living with their parents and have little or no income or assets, they can contact their local township's General Assistance program, which should provide cash assistance to meet their "basic maintenance needs."¹³⁷ Unfortunately, there is no General Assistance program available to residents of the City of Chicago, but Townships outside of Chicago in Cook County and all other counties throughout Illinois must operate such programs. Therefore, jails and prisons should help youth leaving its facilities and going to places in Illinois other than Chicago to apply for General Assistance benefits.

Funding

Federal funds are available for reentry efforts. For example, although several communities across Illinois received the Second Chance Act funded from the US Department of Justice's Bureau of Justice Assistance included a juvenile program to help adults help youth leaving incarceration and re-entering their communities with housing, mental health, and employment needs.¹³⁸ Unfortunately, Illinois did not receive funding for this juvenile pilot. Illinois should advocate for continued expansion of these sorts of juvenile programs and better position itself for funding in the future.

RECOMMENDATION 14: Promote Positive Youth Outcomes Upon Release from Jails and Prisons, Not Just Recidivism

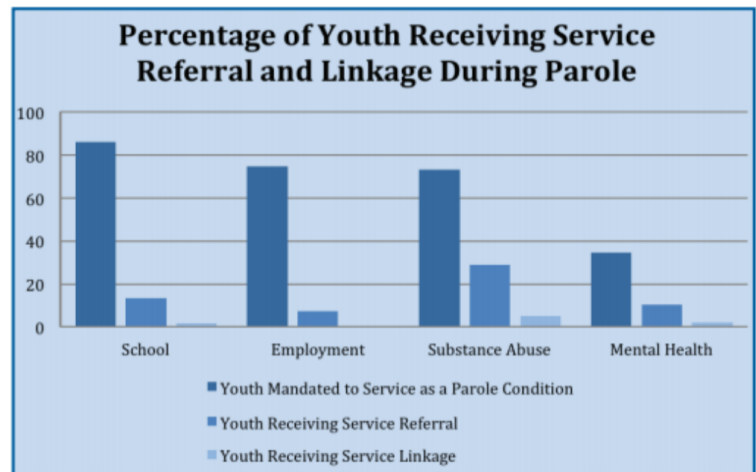
Background

The ultimate proof of whether juvenile justice systems are effectively reintegrating youth is not simply lower recidivism rates, but better youth outcomes. Whereas recidivism rates track either violation of the conditions established upon release or subsequent involvement in the system – generally criminal acts that result in re-arrest or re-adjudication during a three-year period following the youth's release – youth outcomes tracks a youth's transition to a crime-free and productive adulthood, such as their mental health stability, educational attainment, employment status. Today, policymakers and juvenile justice agency leaders in Illinois rely primarily on recidivism rates to measure the effectiveness of the system. Although recidivism is an important part of the story of success following involvement with the juvenile justice system, we must do better.

In 2011, the Illinois Juvenile Justice Commission published a report tracking the frequency with which youth reentering the community from the Department of Juvenile Justice were referred and linked to a community-based program upon their release.¹³⁹ The chart below shows that only 3 percent of the 486 youth tracked by the Commission were linked to community-based services. Mental health treatment was a condition of release for 134 youth, but only 40 youth received referrals and 8 youth were linked. In other words, only 6 percent of youth who were supposed to receive mental health treatment as a condition of release were linked to those services. This tells us a completely different story about reentry from whether or not they commit another crime; it tells us a story about the inadequacies of the reentry system itself.

Some strides have been made by juvenile justice agencies. For instance, the mission of enhancing positive youth outcomes was at least part of the Illinois Department of Juvenile Justice's mission when it was created by the Illinois Legislature in 2006.¹⁴⁰ The Department, however, has struggled to fulfill this mission, in part because it started as an under-resourced, ill-equipped agency attempting to serve the needs of Illinois'

most troubled and vulnerable youth. Enhancing positive youth outcomes has also been challenging as the reentry program has transitioned from IDOC adult parole officers who historically monitored youth on large and blended caseloads to parole officers for youth, known as Aftercare Specialists. The Aftercare Program began as a pilot program in Cook County in 2011 through federal grant funding, and was implemented statewide in 2014.¹⁴¹



Nevertheless, the strides have not been sufficient. According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP), although juvenile incarceration rates have plummeted by over the last two decades, there's been less progress ensuring youth released from facilities or under community supervision succeed by staying crime free, having mental health, achieving academically and getting jobs.¹⁴²

Policymakers and juvenile justice system leaders should use the following recommendations to assess and improve their efforts to evaluate the impact of system interventions in a comprehensive and reliable way, and ultimately, to support only those programs and practices that are shown to reduce recidivism and improve other outcomes for youth.

Changes Needed

1. Develop a Case Management System to Capture All Data Necessary to Track Outcomes for Youth Under System Supervision

Routinely generating positive youth outcomes data requires an updated electronic case management system. A case

management system that collects and analyzes youth outcomes data would provide Illinois with a full and reliable picture of the juvenile justice system's effectiveness for youth reentry. The data would inform taxpayers about whether their dollars are judiciously protecting public safety and helping youth to become crime-free and productive adults. Investing in this system will enable policymakers and agency leaders not only to measure recidivism rates but also to understand how system policies and interventions are driving these results.

Oregon has helped lead the nation in developing a case management system that tracks youth outcomes. In 1997, the state legislature approved funding for the for a new case management system contingent upon the state securing intergovernmental agreements with counties to ensure the system would be collaborative and integrated to serve both the state and counties.¹⁴³ The case management system has become known as the Juvenile Justice Information System, which provides extensive information including tracking youth outcomes data and has been used to generate a variety of reports with aggregate data for policymakers that adhere to confidentiality laws.

2. Develop Interagency Information-Sharing Agreements

The youth outcome data entered into an electronic case management system is likely to come from multiple sources including juvenile justice agencies and community-based service providers. Policymakers should facilitate interagency data-sharing agreements, where necessary, to ensure that staff from all participating agencies can enter data into the system and have access to the full range of available information while also adhering to confidentiality laws.

3. Establish Policies and Procedures to Guide Data Entry and Use

Once an electronic case management system is in place, policymakers should require, and provide funding for, juvenile justice and partner systems to establish policies and procedures for entering and maintaining data, including provisions for training and operator support as well as quality assurance protocols to ensure data integrity and its appropriate use.

4. Require Juvenile Justice Agencies Submit Annual Report on Youth Outcomes to the Legislature and Make Available to the General Public

Policymakers should know how youth have fared in terms of mental health treatment, education, employment, and other important outcome measures while they are under juvenile justice supervision. Therefore, policymakers should require juvenile justice agencies to formally report youth outcome data annually to the legislature and the public. Agency leaders should also work with policymakers to develop an agreed-upon, user-friendly way to report data that helps them to focus on and understand a priority set of key indicators of system effectiveness. This could include tracking the positive outcomes of youth—through aggregate data—for 18 months after they are no longer under supervision.

5. Use Youth Outcome Data to Inform Juvenile Justice Policy, Practice, and Resource Allocation

Policymakers should partner with juvenile justice agencies to establish formal processes through legislation or agency policy to review youth outcomes and evaluate system performance based on established targets for improvement. The budget development process offers an opportunity to tie overall agency funding, as well as resources for specific programs and reform initiatives, to demonstrated progress on achieving these targets. Similarly, juvenile justice agency leaders should develop their own internal processes to review youth outcomes with both management and agency staff, and use these data to identify strategy for improvement and to hold staff accountable for results.

6. Set Improvement Targets

Policymakers should use youth outcome data to identify baseline youth outcome rates and set annual targets for increase linkage to services that are ambitious but achievable. A measurable improvement goal, for example, could be a 10-percent increase over a 1 year period in youth who are linked to services upon release, such as mental health treatment, substance use treatment, school, and employment. These tracking of linkage to services could be based on the services mandated as a condition of their release.

Next Steps



The Task Force has described the problem in Illinois when tens of thousands of youth living with mental health conditions—mostly nonviolent—are arrested in Illinois and flow through the juvenile justice system. The opportunity to divert youth early is wasted, and youth end up in a system that is ill-equipped to provide the necessary treatment and expensive for Illinois taxpayers.

The Task Force urges Illinois to shift resources toward community-based mental health services, which will not only improve outcomes for our youth but allow Illinois to focus greater attention on violent offenders and improve public safety. We must focus on putting youth with mental health conditions on the road to recovery, a road that helps them prevent further contact with the justice system and return to school, work, and family.

This Task Force has laid out 14 recommendations across the justice system that would help bolster our diversion efforts and connect youth living with mental health conditions to treatment. We fully understand that investment, resources, and dedication are needed to achieve these goals. Stakeholder groups must, therefore, work together toward the recommendations to build a comprehensive diversion system in Illinois. Chief among these stakeholders are the Governor, General Assembly, State Agencies, and Community Organizations.

General Assembly

The information provided in this report should serve as a basis to understand the policy and programmatic opportunities that can strengthen diversion for youth who are justice involved. We urge General Assembly members to prioritize these recommendations and take action to implement the policy changes necessary to keep youth out of the juvenile justice system. As noted throughout the report, our belief is that focusing on community diversion is the most advantageous for long term impact.

Governor and State Agencies

Similar to General Assembly members, this report provides a foundation for diversion efforts in the state. As the Governor directs the state agencies in Illinois, there are many opportunities to take action on these recommendations. Ensuring the sustainability of the Comprehensive Community Based Youth Services (CCBYS) program, promoting law enforcement training through the Illinois Law Enforcement Training and Standards Boards, and expanding data collection conducted by the Illinois Department of Juvenile Justice are just a few examples of areas for executive branch action.

Community Organizations

We are grateful for the input provided by many mental health and juvenile justice stakeholders throughout this process. The perspectives from across the state and the expertise shared with us were invaluable. This report represents a culmination of what we heard over the last several months. This should be an opportunity for stakeholders to both see how their organizations fit into this work and to explore how local municipalities can begin taking action implementing diversion programs and recommendations based on their needs. While not all models will be the right fit for the needs of a community, there are many worthy ideas presented in this document. Whether it's developing a Crisis Intervention Team (CIT) for Youth training or considering a juvenile mental health court, these models represent options that can be assessed through existing juvenile justice stakeholder collaborations. We invite stakeholders to learn more about this process and the recommendations shared through upcoming education opportunities, and to join us in advocating for the implementation of these recommendations to ensure their success.

Endnotes

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