

# **JUVENILE JUSTICE INTEGRATED TREATMENT NETWORKS DEVELOPMENT**

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## **HISTORICAL PERSPECTIVE**

The Denver Juvenile Justice Integrated Treatment Network (“DJJITN”) was funded in 1995 by the Center for Substance Abuse Treatment (“CSAT”), which is under the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. In 1994, CSAT, based on its experiences with criminal justice and juvenile justice initiatives, wanted to fund networks that served both juveniles and adults with the hope of improving outcomes for the participants. CSAT goals for the treatment networks were to integrate the efforts of the courts in the criminal justice communities with that of the alcohol or other drug treatment communities and to implement a continuum and comprehensive system of care. CSAT saw a need to develop continuity for the individual as he moved among or through criminal justice or juvenile justice systems. Furthermore, CSAT wanted to demonstrate that networks would be able to expand access to services delivery and show cost efficiency. Ultimately, the outcomes that CSAT wanted to see were lower drug usage, lower rates of recidivism and an increase in levels of positive social functioning.

## ***KEY COMPONENTS OF NETWORKS***

The key components for these networks that CSAT felt were critical were the implementation of a centralized intake system for uniform screening and assessment and a system to track offenders and manage information across the criminal justice and juvenile justice agencies such as courts, jail and community corrections. CSAT also saw the need for consortiums to integrate not only alcohol and other drug treatment, but mental health, primary physical health and other services. The consortium partnerships would be formalized and developed through use of inter-agency agreements to share information, staff and resources.

## ***NETWORKS***

The Denver Juvenile Justice Integrated Treatment Network was formed to meet the purposes that CSAT sought. There are seven CSAT funded networks at this point in time. Four

of them are adult criminal justice networks and three are juvenile justice treatment networks. The juvenile networks are located in Denver, Colorado; Austin, Texas; and Lane County, Oregon.

## **DENVER JUVENILE JUSTICE INTEGRATED TREATMENT NETWORK**

### ***MISSION***

The mission of DJJITN is to build on existing efforts to implement a culturally competent, comprehensive continuum of care across systems to meet the needs of the substance abusing juvenile offenders, at risk youth and their families. The DJJITN identifies the gaps and barriers to effective services and then collaboratively addresses those gaps through a systems change model. The membership is very inclusive - it includes every juvenile justice agency, state and city government agencies, families, family advocacy groups and public and private providers of education, employment, health, mental health, pro-social activities, substance abuse treatment and family services. Denver has been working on collaborative models for quite some time and actually built the DJJITN model on some early collaborative successes. Those successes included two other programs in Denver funded by CSAT. One program had a focus on the juvenile offenders who were abusing alcohol and other drugs (“AOD”) and one was and still is our juvenile TASC program.

## **DENVER JUVENILE JUSTICE INTEGRATED TASC PROJECT**

The TASC model began in the mid 1970’s with a focus on the adult offender. It bridges the alcohol and other drug treatment community with the criminal justice community, utilizing case management to increase the likelihood of the offender’s success in treatment. We adapted the TASC model for juveniles in Denver between 1990 and 1994. The TASC program focused on the community-based youth, which is under the Denver Juvenile Court Probation. Another program called the Pearl Project focused on youth in institutions that are within the Division of Youth Corrections.

### ***JUVENILE TASC PRIMARY COMPONENTS***

#### **Multiple System Involvement**

There were five critical components in these two projects that were the underpinning for the DJJITN. The first was multiple system involvement. Our juvenile TASC program, when we

implemented it, had a very simple goal - to increase the number of juvenile offenders who were abusing substances who were able to receive treatment. The second goal for that program was to implement continuity of care between the point of probation and the point of commitment. Three primary systems needed to be involved in that project to meet its goals. These included the Division of Youth Corrections, Denver Juvenile Court Probation and the state Alcohol and Drug Abuse Division.

### **Provider Network to Build Capacity and Capability**

A second component was the establishment of a network of alcohol or other drug treatment providers. At that time the primary treatment model was hospital based, but the initial three to four community-based programs involved in the project were willing to examine their treatment practices in order to increase access for juvenile offenders and improve outcomes. Within 4 years the four treatment provider network grew to eighteen. Processes were created for training, for information sharing and for capacity and capability development.

### **Collaborative Oversight**

The TASC activities had collaborative oversight. The juvenile TASC program was administered by all three of the previously mentioned agencies through contractual relationships and an oversight team from the three agencies met monthly.

### **Centralized Assessment, Referral to Treatment and Case Management**

A system for centralized assessment, referral to treatment and case management was established. Prior to centralizing these functions, pilot programs had many of the initial participants managing all their own assessments and referrals individually. In a two-year period only twenty-five kids were referred to the project. Whichever agency to which they were referred was the only agency from which they received treatment. The move to centralization not only insured objective assessment and placement based upon standards for levels of care but also insured that the youth were linked to appropriate alcohol and drug treatment.

## **Family Engagement**

The fifth component was family engagement. The Pearl program modeled this by including families in the assessment process; at that time it was unheard of for a correctional institution to do that. They also engaged the families by going out to their homes, instead of expecting them to drive many miles to the institution.

## ***OUTCOMES***

These programs had good outcomes. The TASC program showed a 19% reduction in the rate of recidivism in the year following termination and a 20% reduction in commitment. In addition, the TASC program showed an increase in the levels of positive social functioning by the youth. The number of youth in treatment jumped from twenty-five to over three hundred and fifteen per year over a two-year period. Until recently, however, there has not been a lot of research on what are the characteristics for success or what the programs should look like. However, we knew we needed a network.

## ***WHY A NETWORK?***

Many of the youth were not completing treatment. There was about a 37%-50% rate of completion. Granted, there is research that says that 50% of the youth are going to do okay if you just leave them alone, however, we did not know which youth would be included in that 50%. We did know that if we got the youth in treatment we would reduce recidivism and increase the level of positive social functioning. Also, we found that the TASC program was the first treatment experience for most of the youth who were now adjudicated and on probation or on parole. We wanted to be able to reach them at an earlier stage. The youth also have multiple needs and it was not only for alcohol and other drug treatment. Typically, these youth have been disenfranchised from school and from other pro-social institutions and 35% of them had co-occurring disorders of alcohol and other drug disorders and mental illness. Yet we did not have the linkages with the other providers and systems to offer comprehensive care. A statement by Elizabeth Shore in 1988 states this eloquently: "The Children's Defense Fund concluded that children's problems and need for services were often identified early and often repeatedly, but the services themselves seldom materialized."

## **DEVELOPMENT OF DJJI TREATMENT NETWORK**

### ***GOALS FOR THE DJJI TREATMENT NETWORK 1995***

DJJINT goals are to *expand the identification, assessment, case management and substance abuse treatment* services to include youth at all points in the Denver Juvenile Justice System. Youth should not have to be on probation or on parole in order to access these services. We wanted to *enhance the services* to include mental health, primary health care, educational and vocational training and any other service that would make it comprehensive and meet the needs of the youth and their family. We had a long-term vision, which was to have people trained in their institution of higher learning who were *trained in best practices*. Therefore, we wanted to develop a Center for High Risk Youth Studies, which would provide cross training and develop a baccalaureate degree and certificate programs for current workers on best practices with high risk youth. Last but not least, we needed *to develop a consistent management information system* among the state and local agencies and community providers in order to ensure that we were able to have a continuity or continuum of care.

### ***HOW?***

The five components of a network, multiple system involvement, provider network capacity and capability, centralized assessment, referral to treatment and case management and collaborative oversight all required planning. A year-long planning process was undertaken to look at how business was done, what were the gaps and barriers in the status quo and what were the resources and/or under-utilized strengths that could be brought to implement the network. The outcome of the planning process was to develop a vision of how things could be and an implementation plan for the following four years of the project.

### ***STRUCTURE FOR MULTIPLE SYSTEMS***

A structure for the project was created. We had engaged about 350 people and involved them in the planning process. They represented 125 distinct agencies. The structure that was created is an “inside-out” hierarchy where the power is flipped. The structure was designed to engage all systems and agency expertise. The Denver Juvenile Court is the lead agency, however, it is located in the middle, not at the top.

## ***STRUCTURE FOR MULTIPLE SYSTEMS AND THE PLANNING PHASE***

A structure for the project was created. We engaged about 350 people and involved them in the planning process. They represented 125 distinct agencies including: education, AOD, juvenile justice, law enforcement, mental health, health, employment, pro-social and family services. The structure was designed to engage all systems and agency expertise. The Denver Juvenile Court is the lead agency. Subcommittees did the planning work in identifying gaps and barriers to a comprehensive system of care. The subcommittees were vocational, employment, education, AOD, allied social services, health, mental health, pro-social adjustment, Center for High Risk Youth Studies and juvenile justice. Each person was asked, based upon personal or professional interest, to join one of these subcommittees. The work of the subcommittees was fed into what we call our Local Coordinating Committee, which was composed of chairs of all of the subcommittees plus administrative representatives of all public systems that were previously mentioned. The subcommittees were staffed with “loaned” managers from four public systems - the metropolitan State College of Denver, which is where our Center for High-Risk Youth Studies is located, the Division of Youth Corrections, the Alcohol and Drug Abuse Division and the Denver Public Schools. We paid for them to loan us, for one year, some of their best management people and we got their best. Their job was to staff the subcommittees and the local coordinating committee and they brought with them expertise from their own disciplines, and a feedback loop to their own systems, which helped to engage and maintain the engagement of those key systems.

The first step in our network development was to build a map so that we would know where we were going. We did this through a very simple visioning exercise. The question was, “It’s the year 2001 and a system is in place that effectively services the AOD juvenile offender and family. What does it look like?” The only rules we had were to be creative, think globally and take risks. The task for the planning by the Local Coordinating Committee and subcommittees was answering these two questions: “Is treatment developmentally and culturally appropriate for the juvenile offender population?” And, “what policies, procedures and gaps in pro-social, education, mental health, employment and health systems are barriers to the delivery of effective integrative services?” Because people self-selected into these subcommittees to do this work, we had a very rich mixture of expertise and interest. Our education subcommittee, as

an example, had as members not only teachers and school managers and administrators and school social workers, but also alcohol or other drug treatment providers. Each of these committees had to look at that specific area or discipline and identify these gaps and barriers. All of the gaps and barriers identified by all of the subcommittees and the local coordinating committees fell into these areas: access, information, continuity of care, family, policies and procedures, culture, program quality, quantity and content, linkages, resources and training. They went through the process and came up with the implementation plan and the first thing the Local Coordinating Committee did to get the implementation plan kick started was to agree to eliminate all barriers to access to the centralized case management assessment referral to treatment for kids. The model they designed was that the public systems who are responsible for the AOD abusing juvenile offenders are responsible for screening and identifying which youth are more likely to be those needing treatment. They identified a screen that was developed to complement our assessment instrument, which is called the Substance Use Survey, developed by Dr. Ken Wanberg. Then they all agreed to the same protocol of screening and referring juveniles to our juvenile TASC program, which then performs a full blown assessment, gets them into treatment and comprehensive services, and provides case management.

### **Implementation Phase**

We formalized the relationships with our network and entered into formal memoranda of understanding with our members. They all committed to working with the kids referred to them, to participate in training, to participate in MIS development, evaluation and other activities. Here are some examples of implementation strategies. Mental Health – the mental health subcommittee decided that we needed a mental health specialist assigned onsite with our juvenile TASC specialists. Our juvenile TASC specialists are trained alcohol and other drug treatment counselors. They did not necessarily have the comprehensive, holistic approach, so a mental health specialist position was created and placed on staff. That specialist has been involved in training the staff through consultation, as well as providing direct evaluations of kids and families as they are brought in, and then integrating the mental health plans into the AOD treatment plans. Putting a specific emphasis on co-occurring disorders included not only the mental health specialist. We also entered into a pilot of Multisystemic Therapy, with which many of you are probably familiar. The education subcommittee identified a need for the educational

liaison position to integrate education into the TASC assessment and services processes and to bridge the juvenile justice and education system processes.

We continued to do a lot of capacity and capability building. We trained 250 network members within our first year and a half on the same curriculum on best practices of working with the AOD abusing juvenile offenders and their families. Every discipline and system was represented in this. It really pushed the issue of family strength-based approaches to us as well. Every one of our cross trainings had a panel of family members on it. These were parents and some siblings of kids who were either co-occurring disordered or who were in need of AOD treatment. They told their stories on what it's like to be a family member and/or parent of a youth who is involved in the juvenile justice system. It opened the eyes of many of our people and was a very powerful way to educate us on how we respond to families, how families see us, and how we set up our own barriers to families. I give a lot of credit to our Colorado chapter of the Federation of Families for Children's Mental Health. I believe that there is a chapter in every state. I do not know if you have any connection with your local chapter but I highly recommend them. It is a fine advocacy organization. We also would train people on what was happening in the field. We had training programs on managed care assets in youth development. We did training on leadership for our local coordinating committees and subcommittees and on what is a management information system.

**Information sharing:** When we came into this, we were thinking that MIS was the least of our worries. Of all the networks, ours was probably the slowest in getting our automated management information systems started, but there are so many other critical areas around sharing of information that are beyond automation of the information that you share. We got very keyed in to the family strength based way of thinking on redundancy of data collection. Families answer the same questions over and over at every point of entry they have into the juvenile justice system and social services, child welfare system, the schools and any services to which they might be referred or with which they wish to engage. We wanted to have an impact on that and we also streamlined the intake processes. This led us to ask, "how are we going to share this information with everybody?" We developed, with the assistance of the State Department of Human Services, what we call a common informed consent form. A parent will sign and specify

the type of information that they are willing to have shared among network membership. They sign this once per year. The feedback from the families is very positive. They were tired of inappropriate information being shared, but more frequently they were tired of information not being shared among agencies. We had cases where families demanded that information be shared and the professionals refused to share it. We then had a multi-agency, multi-system common consent form and confidentiality issues came up. We developed an interdisciplinary, inter-system confidentiality manual for use by professionals. We then needed to train people on what can be shared and what cannot be shared, what can be shared without consent and what can be shared with consent.

**Question:** Was this all worth it?

**Answer:** Yes. We have seen benefits clearly at three levels, the systems level, the client level and the services level. At the systems level it was evident in the collaboration and operational pieces; at the client level in functioning and outcomes; and in services delivery at the service level. The preliminary findings on the systems benefits, based on our evaluation, were improvements in referral patterns of kids among systems, the flow of information, and case management practices within and among systems have improved. They see an improvement in the comprehensiveness of assessment and they see more visibility and improvements in family supports. By eliminating barriers to access and ensuring comprehensive services, a family or youth should be able to enter anywhere. The services have expanded in scope, duration and quality. They are more intense, the length of stay has increased and they are available. The family piece has also shown significant improvement. The family's involvement and parents' engagement in AOD treatment and the more comprehensive services, particularly mental health, have increased. There is a greater likelihood that the kids will abstain from AOD use and their ability to handle life problems has improved. They are better able to function in school, with their family, in a job and to stay out of trouble with the law.

### **Lessons Learned**

If you embark upon doing a network kind of thing, one of the primary things I have learned is that you do not know what you do not know. You walk into a meeting and the outcome is so much better than the preconceived notion that you walked in with. It is amazing.

The network really does not look like what we thought it would. Our goal has remained the same and it created the framework for the activity. The network serves as an investigator of issues and of gaps and barriers, and it serves as an innovator. The network creates an environment within which things can be tried out across systems. It is an instigator. It is an incubator for those practices. Here is an example. One of the subcommittees, the Integrated Human Services subcommittee, had a strategy to create a single entry process for kids and their families coming into the system, expanding our scope beyond the AOD abusing juvenile offenders. They felt that there were inconsistent assessments and that if you could get to kids earlier, before they come into the system, it will keep them out of the system. We all have parents calling us, saying “my kid is out of control, can you help me?” If you are in juvenile justice, the first thing you say is, “has she been arrested yet?” If the answer is no, then you ask if they’ve tried social services. Chances are that they have tried them all. Nobody can provide that family with the assistance they need because they do not fit in a category or definition. The subcommittee was very passionate about that. We went through an RFP process with the Office of Juvenile Justice and Delinquency Prevention and got a planning grant for their community assessment center model, which matched what subcommittee strategy. We have implemented a family strength-based assessment, service coordination, and family advocacy process for at risk youth and juvenile offenders coming into our system. Our Juvenile Drug Treatment Court was relatively easy to put together because the cross system relationships already had been established.

Our network also has been involved in other related initiatives. We have a state mental health system of care initiative that utilized our network model of collaboration and the Denver Public Schools used our network model as a basis for a Safe Schools initiative.

Just a few thoughts on why it works: Recognition of the multiple needs of the AOD abusing juvenile offenders and their families, and engagement of all systems with a responsibility or expertise in need or strength areas. The engagement also means that you don’t say no to anyone who wants to join. It is a totally inclusive, non-excluding model. You empower the expertise of each entity or person and focus on the integration of all of it. A network doesn’t start as a group of experts. Everyone who comes in changes the network just by virtue of what they bring to the table.

## ***CSAT CRITICAL ELEMENTS***

CSAT, based on its experience with the juvenile justice treatment networks, came up with a list of critical components for juvenile justice networks. These critical elements include a planning process, a lead agency, public/private partnerships, identification of stakeholders, memoranda of understanding, a commitment from judges, management of the network, screening and assessment, case management, management information systems, training capacity, a self adjusting evaluation process and continuity of care.

A quote from John Shaw, whom, I have been told, was a superintendent of the Minneapolis School District, describes the change process and the philosophical shift in approach that network development demands. His mission was to change the public education approach to children from a problem, or deficit based model, to an asset based model: “The future is not a result of choices among alternative paths offered by the present, but a place that is created. First in mind and will and created next in activity. The future is not some place we are going to but one we are creating. The paths are not to be found but made, and the activity of making them changes both the maker and the destination.” Another wise quote from an anonymous person on change: “If you always do what you always did, you always get what you always got.”

### **About the Presenter**

Jennifer S. Mankey, MPA, is the Project Director of the Juvenile Justice Integrated Treatment Network, Denver Juvenile Court, Colorado. Ms. Mankey has worked to integrate and expand the comprehensiveness of treatment services for Denver’s substance abusing juvenile offenders. She has twenty-seven years of experience in private and public sector juvenile and adult offender programs.

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