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THE CROSSOVER YOUTH PRACTICE MODEL (CYPM)

CYPM in Brief: Behavioral Health and Crossover Youth

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Crossover Youth Practice Model (CYPM)

The Crossover Youth Practice Model (CYPM) was developed by the Center for Juvenile Justice Reform (CJJR) at the Georgetown University McCourt School of Public Policy to improve outcomes for youth who are dually-involved in the child welfare and juvenile justice systems. The model uses a research-based approach to assist child welfare, juvenile justice and related agencies in adopting policies and practices that better address the needs of these youth and improve their life outcomes. The term crossover youth refers to all youth who have experienced some form of abuse or neglect and who engage in delinquent behaviors regardless of their involvement in the system. This brief is the first in a series that addresses various important issues faced by crossover youth and the systems that serve them.

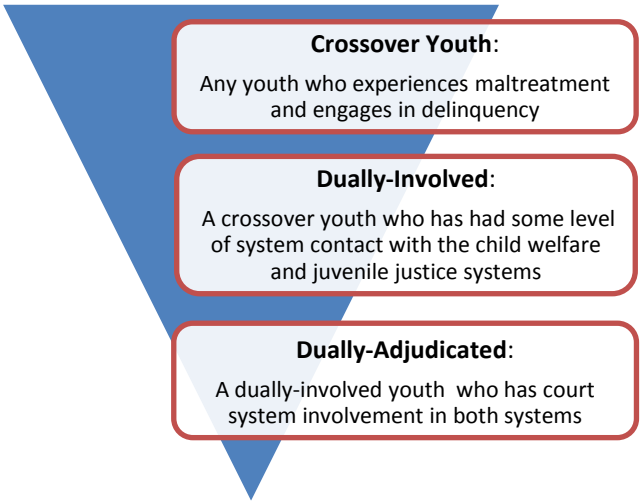

Figure 1: Definitions

Behavioral Health

Behavioral health issues, which include mental health (MH) and substance use (SU) disorders, can significantly challenge the safety and well-being of youth and their families. These risks may be particularly elevated for crossover youth. Due to the potential long-term impact of adolescent behavioral health issues on development and social functioning, it is in the interest of policy-makers and practitioners to monitor and address the behavioral health status of youths in these systems (Keller et al., 2010). In order to assist child-serving practitioners in these efforts, this issue brief will discuss:

- the relationship between behavioral health and crossover youth,
- the ways in which the Crossover Youth Practice Model (CYPM) addresses behavioral health, and
- how one jurisdiction has utilized CYPM to address behavioral health outcomes.

Behavioral Health, Maltreatment, and Delinquency

Delinquent and maltreated youth often struggle with behavioral health disorders throughout their childhood and into adulthood. The prevalence of these disorders is higher for youth in the child welfare and/or juvenile justice systems than the general public. A 2008 study of dually-involved youth between the ages of 9 and 18 years in Los Angeles County found that 83 percent of this population was associated with at least one behavioral health problem. Twenty-eight percent were found to have a mental health problem without a substance use problem, and 17 percent had a substance use problem without a co-occurring mental health issue. Thirty-eight percent of dually-involved youth had both mental health and substance use problems (Herz and Ryan, 2008). A more recent study of jurisdictions employing CYPM across the country found that nearly two-thirds of dually-involved youth had a documented mental health problem and one-quarter struggled with the use of alcohol or other drugs (Herz and Fontaine, 2012). These behavioral health challenges compound many of the psychological, biological, and social issues these young people may already be facing. Since these youth may be involved in multiple systems (Behavioral Health, Juvenile Justice, Education, Child Welfare, Medicaid, etc.), practitioners and child-serving agencies need to coordinate services in order to ensure that these crossover youth receive the behavioral health treatment and care they require.

There are several mechanisms through which behavioral health issues intersect with the crossover youth population. Behavioral health issues may be sparked by the same social, biological, and environmental factors that often correlate with child maltreatment and juvenile delinquency. For example, research suggests that childhood poverty may have a causal relationship with maltreatment, delinquency, and behavioral health issues independently (Yoshikawa et al., 2012; Cancian et al., 2010; Pagani et al., 1999; Ludwig et al., 2001). This mechanism suggests that behavioral health issues coincide with maltreatment and delinquency, but are not necessarily caused by these events. However, some researchers suggest that behavioral health issues may stem from the experience of childhood maltreatment and delinquency, therefore serving as a potential bridge that links children who have been maltreated to delinquent behavior (Bender, 2010). This may be especially true for youth that begin in the child welfare system and subsequently crossover into the juvenile justice system.

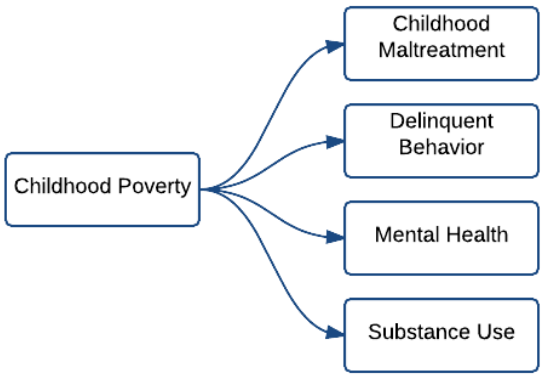

Figure 2: One Potential Mechanism Connecting Behavioral Health and Crossover Youth

Child abuse is a stressful and traumatic experience for victims that can have long-term consequences. Recent brain imaging studies suggest that the stress from maltreatment can actually alter the physical development and size of the adolescent brain, making victims more prone to substance abuse and mental health disorders (Teicher et al., 2012; Teicher et al., 2003). Maltreatment during childhood can significantly increase the risk of problem behaviors such as teen pregnancy, delinquency, drug use, poor school performance, and mental health issues (Topitzes, 2012; Kelley et al., 1997). More specifically, the trauma and stress of maltreatment and involvement in the child welfare system is associated with a higher risk of developing mental health issues such as post-traumatic stress disorders (PTSD), major depression, psychopathy, and other serious mental disorders (Bender, 2010; Keller et al., 2010; Kilpatrick et al., 2003; Taussig et al, 2001; Weiler and Widom, 1996). In turn, these mental health disorders can externalize in antisocial or violent behaviors that may result in delinquent activities, substance use, and involvement in the justice system (Mallet, 2013; Bender, 2010; Rosenblatt et al., 2000; Weiler and Widom, 1996). This mechanism presents a direct line between maltreatment, trauma, mental health and delinquency. While the actual relationship between these elements may not always be straightforward, addressing any piece through treatment and services may help disrupt the connection between maltreatment and juvenile justice. On the other hand if a youth does not receive appropriate treatment, mental health disorders can negatively affect a youth's response to treatments and interventions provided in the juvenile justice setting (Kinscherff, 2013; Vincent, 2012). This may result in worse outcomes and higher recidivism rates for affected youth.

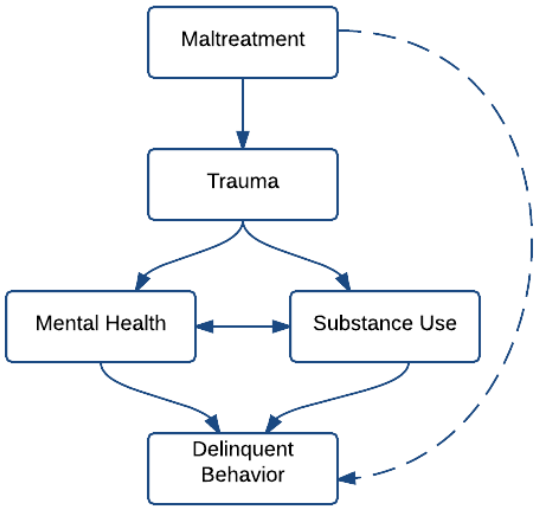

Figure 3: An Alternative Mechanism Connecting Behavioral Health and Crossover Youth

As with mental health disorders, substance use may also serve as a distinct bridge for youth to crossover from child welfare to juvenile justice. Youth who have been maltreated are more likely than the general population to report substance abuse problems in their lifetime (Bender, 2010; Moran et al., 2004; Kilpatrick et al., 2003). These youth may not have healthy outlets to deal with the trauma of their abuse and turn to alcohol or drugs in order to self-medicate. This may be especially true with girls, for whom PTSD symptoms are significantly associated with problematic substance use (Lipschitz et al., 2000). In turn, this substance use can lead to delinquent behavior that drives youth into contact with the juvenile justice system by increasing

aggression and reducing inhibitions or clear thinking. An illicit drug habit may also require youth to steal or commit crimes that allow them to purchase drugs, or force youth to interact with other drug users and dealers who encourage negative or delinquent behavior (Brook et al., 1996). Substance use has been shown to be highly predictive of delinquency, so early intervention and treatments that decrease drug use early may serve to decrease future delinquent behavior (Lispey and Derzon, 1998 as cited in Bender, 2010; Brook et al., 1996).

Meeting the Behavioral Health Needs of Crossover Youth

The relationships between maltreatment, behavioral health and delinquency are complicated and unique for each young person. Understanding the individual experiences, strengths, and challenges of crossover youths is a crucial step in improving outcomes for this population. Childhood maltreatment and violence can be traumatic experiences for youth. Youth who have been traumatized by violence are more likely than their peers to come in contact with the juvenile justice system (Adams, 2010) and experience other behavioral health challenges. Trauma-informed assessments can help agencies correctly diagnose a youth's needs and maximize available resources to improve outcomes (Kerig, 2013; Adams, 2010; Buffington et al., 2010). Similarly, gender-informed practices recognize that boys and girls may experience trauma and behavioral health challenges differently, and, in doing so, reduce the risk of re-traumatizing youth in a justice environment (Conrad et al., 2014; Espinosa et al., 2013)

In addition to becoming trauma- and gender-informed, child-serving agencies need to coordinate services for children with mental health and substance use disorders in order to prevent crossover and reduce recidivism (Herz et al., 2010). Coordinating services for youth involved in the child welfare and juvenile justice agency is challenging, and inefficient coordination can limit a child's access to necessary resources. Research shows that clearly

CYPM Recommendations

- An "our kids" mentality
- Collaboration at all levels of the involved agencies and case processing
- Inclusion of substance use and mental health providers in multi-disciplinary team meetings
- Execution of consent forms to enable information sharing and collaboration
- Joint assessment processes that address mental health and substance use issues
- Coordinated case plans that address mental health and substance use issues
- Use of evidence-based treatment programs and practices
- Use of trauma informed practices and gender specific services

defining agency responsibilities and sharing administrative data can improve access to inpatient and outpatient behavioral health services for crossover youth (Chuang and Wells, 2010). Likewise, wraparound-services and the system-of-care philosophy, which includes coordinating community-based, comprehensive and integrated services for children and families with complex needs across the child welfare, juvenile justice, and other sectors, has been shown to improve clinical outcomes and lower recidivism rates for youth with behavioral health needs (Pullmann et al., 2006).

Behavioral health services should begin with a screening of youth for substance use and mental health risks. Screenings can occur at a doctor's office or when a child comes in contact with a child-serving agency. By having youth answer questions about his or her behaviors, thoughts and feelings, child-serving professionals can use a validated screening tool to identify that youth's risk of mental health or substance use disorders. If a screening indicates that the youth is at high risk for behavioral health issues, he or she should be formally assessed by a behavioral health professional. Assessments should be done with a psychosocial assessment instrument that is evidence-based and can confirm the presence of a mental health or substance use disorder (CMS, 2015; SAMHSA, 2011). Once a behavioral health disorder has been identified, intervention/ treatment should begin. Research indicates that evidence-based and developmentally appropriate psychosocial treatments can be effectively used to improve outcomes for youth with behavioral health issues (CMS, 2015; Pagani et al., 2010; D'Amico et al., 2005; SAMHSA, 2002). Screening, assessment, and intervention/treatment comprise three critical steps in addressing a young person's behavioral health issues. Child-serving agencies should be prepared to offer these services or refer adolescents to appropriate behavioral health practitioners.

Perspectives from the Field

Screening for Everyone, New York City, NY (NYC)

As part of the CYPM, NYC[1] established a Mental Health Work Group to ensure that behavioral health issues were given adequate attention in their system change efforts. The Work Group, made up of representatives from the City Administration for Children's Services, Department of Probation, Law Department, Health & Hospital's Corporation, State Office of Mental Health and Office of Court Administration (Family Court), Legal Aid Society, community based organizations, and other programs, established behavioral health screening as its first priority. While they did not know who would administer the screening or how it would be funded, they knew that

[1] The CYPM is at various stages of implementation in all five New York City boroughs, beginning with the Bronx in 2012; Brooklyn in 2013; and Manhattan, Queens, and Staten Island in 2015.

success could only be accomplished by making sure the right youth were receiving mental health treatment. Fortuitously around this time the New York City Council made available grant money for local youth serving agencies to address the mental health of "any youth at-risk of juvenile justice involvement." Part of the requirement for funding was to become trained in a trauma-informed approach, including the use of standardized protocols. While this grant money serves all at-risk youth in NYC, regardless of system involvement, the CYPM workgroup has made special efforts to ensure that crossover youth access these services.

The screening protocol was named the "Life Experience" Screen to avoid stigma associated with mental health issues or treatment. It recognizes the importance of both a trauma-informed and strength-based approach in working with youths and families involved in the child welfare, juvenile justice, and/or behavioral health systems. The screening protocol includes the use of four instruments and is based on a trauma-screening protocol that was developed by Dr. Jennifer Havens and her team from Bellevue Hospital as part of a SAMHSA grant for use with youths in juvenile detention. That protocol includes a screening tool for trauma (the UCLA PTSD Inventory), depression (the PHQ-9) and problematic substance use (the CRAFFT). In addition the CYPM workgroup recommended the inclusion of a strength-based screening tool (the Behavioral and Emotional Rating Scale), which is completed by the youth and their families as a means to further engage them in the process.

The screening is free of charge and takes an estimated one-hour to complete. The tools consist of simple questions for the youth and/or parent to answer on their own or with the screener. It does not require any invasive procedures, can be repeated as often as necessary, and does not interfere with any formal psychological tests or mental health treatment the youth may already be receiving. If a youth "flags" on any area of the Life Experience screen, the community based organization conducting the screen will automatically arrange for a more in-depth mental health evaluation, upon consent. This secondary evaluation may include information-sharing (upon receiving consent) with other providers from whom the youth and/or family previously has received or is currently receiving mental health services, in order to develop a collaborative treatment plan that is sufficiently inclusive but avoids redundancy. Depending on the outcome of that evaluation, the youth/family may be offered mental health services in addition to or instead of those, if any, they are already receiving from other providers

While youth involved with the Juvenile Justice system at any phase prior to residential placement can be referred for a screen, NYC has unique protocols in place to address crossover youth at the point in time when a youth with an open dependency case becomes involved with the juvenile justice system. Specifically, on a daily basis, the Confirm Unit within the Administration for Children's Services (ACS) compares lists of all youth who will be going to court

that day with the ACS database of open cases. One list comes from the city-wide detention intake, which identifies all youth who have been arrested and held overnight. The other lists, one from each borough, include all youth who have received a Family Court Appearance Ticket. If there is a match, ACS ensures that the primary child welfare worker is notified of the arrest. Upon notification, the case worker is responsible for informing the family of the free "Life Experience" screening and encouraging them to provide consent for communication between the child welfare and juvenile justice agency, as well as the CBO conducting the screen.

To date making screening readily accessible has fast tracked the ability of crossover youth to access needed mental health or substance use services. With the "Life Experience" Screen as the doorway, youth and families appear more willing to enter into relationships with community based organizations, resulting in greater continuity of care and a more effective response to the behavioral health issues they face.

For more information about the Crossover Youth Practice Model, please visit: http://cjjr.georgetown.edu.

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