

**ASSESSING THE USE OF LAW ENFORCEMENT BY
YOUTH RESIDENTIAL SERVICE PROVIDERS**



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Introduction

Disability Rights Maine (“DRM”) produced this report as part of an effort to understand why Maine’s youth with disabilities are disproportionately arrested, criminally charged, and incarcerated. This effort began when the Maine Department of Corrections (“DOC”) issued a report indicating that as of July 2016, approximately one third of the youth committed to Long Creek Youth Development Center (“Long Creek”) had come directly from residential mental health treatment programs.¹

“The cost of incarcerating our youth is astronomical. The cost of incarcerating our youth due to mental illness is inexcusable.”²

As DRM explored this issue, it became clear that law enforcement calls from these residential treatment programs often resulted from behaviors that were likely manifestations of the disabilities for which the youth were being treated.

This report is based on data DRM received from law enforcement agencies and Department of Health and Human Services (DHHS) reports. It provides an analysis of that data and suggests some opportunities for reform. As the Protection and Advocacy (P&A) agency for people with disabilities in Maine, DRM believes that all youth with disabilities have the right to appropriate and effective treatment in the least restrictive setting – which is rarely, if ever, a correctional setting. DRM is hopeful that this report will help advance the conversation about how to keep youth with behavioral health needs in the community, and out of the juvenile justice system.

To understand the problem, it is helpful to have some information on the continuum of care for youth with disabilities in Maine. Federal and state laws require that treatment be delivered to youth and their families in the least

¹ Profile of Youth Committed at Long Creek Youth Development Center as of July 1, 2016 Report. Available at <http://bangordailynews.com/2017/02/28/uncategorized/document-long-creek-profile-final-report-2016/?ref=relatedSidebar>

² “An Improved Police Response to Juveniles in Crisis: Overview and Discussion: Five Year Trend Analysis (2010-2015),” page 6, Sgt. Jonathan Shapiro M.A., April 2015.

restrictive setting.³ Intensive Temporary Residential Treatment programs (“residential programs”) provide “twenty-four (24) hour per day, seven (7) day per week structure and supportive living environment and active behavioral treatment, as developed in a treatment plan.”⁴ In order to justify treating a youth in this out-of-home setting, Maine regulations explicitly require that there be a “significant potential that the child will be hospitalized, or there is a clear indication that the child’s condition would significantly deteriorate and would require a higher model of service than can be provided in the home and community.”⁵ A youth must also meet additional criteria, including an Axis I or II diagnosis from the most current version of the Diagnostic and Statistical Manual (“DSM”) that has lasted for at least six (6) months or is expected to last one year in the future; and must exhibit a need for “therapeutic treatment or availability of a therapeutic on-site staff response on a 24 hour basis.”⁶ Moreover, eligibility criteria for this service include “[s]ignificant recent aggression across multiple environments or severe enough within one environment to have caused serious injury or there is significant potential of serious injury to self or others; or recent homicidal ideation with risk of harm to others, or recent suicidal ideation with risk of harm to self,” among other behaviors.⁷

These services are mostly funded through Medicaid (“MaineCare”) and DHHS currently contracts with eight private providers statewide to deliver the services.⁸ DHHS reports that there is capacity to provide residential services to over 300 youth.⁹ However, many providers state that they are not filling all the beds in their programs, due to staffing challenges and the particular needs of the youth currently within their programs. That said, even though these facilities are not generally operating at capacity, DRM assumed full capacity when generating the numbers contained within this report.

³ See: *e.g.*, 42 U.S.C. § 12101; M.R.S.A. 34-B Chapter 15, § 15002(2)(A). See also: *Olmstead v. L.C.*, 527 U.S. 581 (1999).

⁴ MaineCare Benefits Manual, Chapter II, § 97.01.

⁵ MaineCare Benefits Manual, Chapter II, § 97.02-7(2).

⁶ *Id.*

⁷ MaineCare Benefits Manual Chapter II, § 97.02-1 and 2.

⁸ These providers are: Spurwink, Sweetser, KidsPeace, NFI-North, Becket Family Services, Aroostook Mental Health Care (AMHC), Opportunity Alliance, and The Northern Lighthouse Inc.

⁹ “Child Mental Health PNMI Bed Occupancy Daily Report,” KEPRO, *available at* <http://www.qualitycareforme.com/media/1465/pnmi-bed-occupancy-child-mh.xls>

Youth enter residential programs from many different settings. Some of them are found eligible for this level of care and remain in their family home until a placement is available. Some await placement in much higher levels of care, like the local emergency department, hospital, crisis stabilization unit (“CSU”), or correctional facility.

Unfortunately, the behavioral health system in Maine is overburdened at every level. Youth wait for months (or in some cases years) for the least restrictive level of care--outpatient or in-home and community services. Because of a lack of necessary and appropriate home and community based services, sometimes these youth will find themselves in crisis, and require a higher level of care, which would not have been necessary with the proper in-home supports. This taxes the system - including residential programs, the CSUs, and the psychiatric hospitals - each of which has youth in their programs that do not need that level of care, but remain for want of a safe discharge option. In other words, these youth stay for months or years in restrictive settings because they cannot access a more appropriate level of treatment, despite being qualified and eligible.

Throughout the continuum of care, crisis services are intended to be a safety net and point of contact for youth experiencing a behavioral health crisis. There is a statewide hotline which anyone can call for emergency behavioral health services. These crisis “[s]ervices are oriented toward the amelioration and stabilization of these acute emotional disturbances to ensure the safety of a member or society and can be provided in an office or on scene. ‘On scene’ can mean a variety of locations including member homes, school, street, emergency shelter, and emergency rooms.”¹⁰ Parents, educators, and residential providers all have this resource available to them when a youth is in crisis. Unfortunately, all too often, concerned parties call law enforcement instead of crisis when there is a behavioral health emergency.¹¹

This is problematic for several reasons: 1) crisis staff have the training and expertise necessary to respond appropriately;¹² 2) law enforcement resources are

¹⁰ MaineCare Benefits Manual, Chapter II, § 65.06-1.

¹¹ The reasons behind this deserve further exploration. Anecdotally, parents report that when they call the crisis hotline, they are often told that they may have to wait hours for a crisis worker to come to the home, and they are advised to go the emergency department and/or call law enforcement.

¹² “Staff providing Crisis Services must have an MHRT (Mental Health Rehabilitation Technician) Certification at the level appropriate for the services being delivered. Supervisors of MHRT staff must be clinicians as defined in 65.02-11, within the scope of their licensure.” MaineCare Benefits Manual, Chapter II, § 65.06-1.

diverted unnecessarily; and 3) youth may incur criminal charges stemming from a behavioral health emergency.

Sometimes, as a result of these criminal charges, youth are brought to Long Creek Youth Development Center (“Long Creek”). This is Maine’s only juvenile correctional facility.¹³ It typically holds under 100 juvenile inmates, both male and female, and contains six functioning units (one unit for detained boys; one medium-risk boys’ unit; one high-risk boys’ unit; one unit for both detained and committed girls; one unit for low-risk transitioning boys; and the Special Management Unit).

According to a report produced by the Department of Corrections (“DOC”) in January 2017, as of July 2016, 29.5% of youth had come directly from residential treatment, and 84.6% had three or more mental health diagnoses when they came to Long Creek.¹⁴

DRM has worked directly with many of these youth, and conducts monthly monitoring visits to Long Creek. Unfortunately, Long Creek has become the default placement of last resort for youth who fall through the cracks of the behavioral health system – the unofficial, yet over-utilized, most restrictive level of care. Although Long Creek provides some access to mental health care, it is not the purpose of the facility, nor is it an appropriate treatment setting.

“[Long Creek] is not medically equipped to deal with the delicate needs of these vulnerable youth.”¹⁵

Because Long Creek is not equipped to deal with youth with significant behavioral health needs, and because almost 30% of the population there came directly from

¹³ In July 2015, Mountain View Youth Development Center in Charleston, Maine stopped serving committed youth and transferred its committed population to Long Creek. But youth are still sometimes detained at Mountain View while awaiting adjudication.

¹⁴ Profile of Youth Committed at Long Creek Youth Development Center as of July 1, 2016 Report. Available at: <http://bangordailynews.com/2017/02/28/uncategorized/document-long-creek-profile-final-report-2016/?ref=relatedSidebar>

¹⁵ Long Creek Board of Visitors Annual Report FY’16, page 2. Available at: <http://www.pressherald.com/media/document/long-creek-board-visitors-2016-report/>

a residential program, it is important to ask why youth are moving from the behavioral health system to the correctional system in such high numbers.

DRM sought to better understand this issue by researching the calls made to law enforcement agencies from residential programs. After analyzing data from 21 law enforcement agencies as well as all the Reportable Events¹⁶ from DHHS for the same time period, DRM found that residential staff frequently call law enforcement for behaviors that are manifestations of the youths' disabilities and the reasons the youth are in treatment. DRM further found that although DHHS requires providers to report any call to law enforcement, two thirds of these calls go unreported.

¹⁶ Residential providers are required to make reports to DHHS about categories of incidents that include Dangerous Situations, Death, Medication Related Event, Neglect, Physical/Verbal Abuse, Restraint, Rights Violation, Serious Injury to Consumer, Sexual Abuse/Exploitation, and Suicidal Acts/Attempts/Threats. See: <http://www.maine.gov/dhhs/ocfs/cbhs/provider/reportable-events.shtml>

Data Collection

DRM requested information from state, county, and local law enforcement agencies regarding calls for assistance from residential programs from January 1, 2016 through January 31, 2017.

All 21 law enforcement agencies provided information responsive to DRM's request. Some law enforcement agencies provided basic information, including the date, who called, and a brief statement as the reason for the call; while others provided that information and detailed descriptions of the incident. Once DRM removed calls that were unrelated to juveniles from the data set, there were 815 documented calls to law enforcement from residential programs over this 13 month period.

DHHS requires that residential programs report any call for assistance to a law enforcement agency as a "dangerous situation" within 24 hours of the incident.¹⁷ DRM requested and reviewed the incidents that were reported to DHHS that corresponded with the same facilities and the same time period as the law enforcement records. Then DRM cross-referenced these two sets of records.

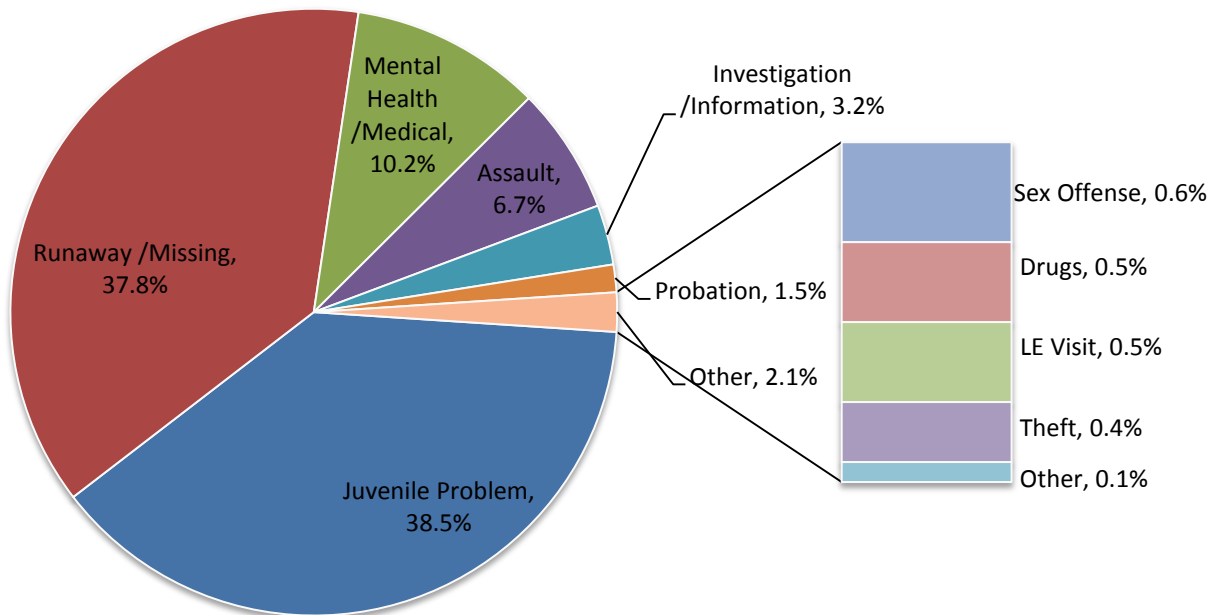
¹⁷ Reportable Events Matrix (updated 1/2017) available at <http://www.maine.gov/dhhs/ocfs/cbhs/provider/documents/OCFSReportableEventsMatrix3.20.17.docx>

Data Analysis

DRM found that there were many reasons calls were placed from residential programs to law enforcement agencies. However, the majority of calls appeared to be for reasons related to the youth’s disability and need for treatment, as seen in Figure 1 and explored further below.

Figure 1

Reasons for Calls to Law Enforcement from Residential Treatment Facilities



A significant number of calls were coded as a “Juvenile Problem.” This encompasses a wide array of incidents: property damage, harassment, threatening, disturbance, misuse of 911, misuse of fire alarm, “out of control youth,” youth barricading room, “acting up,” or any combination of behavioral health/medical and assaultive behaviors. For example, one police report detailed a situation where police were asked to take a youth to a CSU, even though the youth was not in crisis:

“[Facility] staff requesting assistance with transporting [Youth] for evaluation. Upon arrival she was in her room relaxed and has been placed on a two on one watch. She made suicidal statements, threats of violence and denied that she tried to kill herself with her necklace three days ago...[Youth] denied transport, stating that she has a medical right to refuse...” The officer then spent two hours at the residential program and determined no basis for transport. After telling the staff he would not transport, *“one staff member started crying, screaming at me ‘if she kills herself you are at fault,’ she then went into the medications room, smashing the wall with her fist and hollering. She displayed far more reason for transport than the 13-year-old does.”*

Another incident, summarized from police records, shows that police were called when a youth was upset about a call home to her mother:

Law enforcement responded to call that a youth at a residential program was causing damage to an office. The youth had been on the phone with her mother, and then ripped the phone off the desk and began throwing things around the office, before being restrained by three staff members. Staff told the officer the youth *“had a bad talk with her mom.”* The night shift supervisor requested that *“due to the extent of the damage, they would like the [youth] charged.”*

After “Juvenile Problem,” the second most prominent category within the data set is “Runaway/Missing.” This may include a youth simply walking to the edge of the property or walking out of the building without staff permission.¹⁸ In fact, there are several different types of “Runaway/Missing” reports. In some, the youth is off the property but staff have eyes on the youth. In others, the residential program has lost track of the youth entirely. And in some cases, law enforcement does not arrive until after the youth has returned to the program. For example, law enforcement was called when a youth who had eloped from the program returned:

¹⁸ The majority of calls to law enforcement in the “Runaway/Missing” category are from a single program—Sweetser in Saco. Sweetser has previously reported that its practice at this program is to not follow youth into the woods surrounding the property. Instead, they contact law enforcement.

“[Youth] was not in crisis nor did she demonstrate any hostile acts. [Youth] claimed she want to get something to eat upon returning the staff would not allow her back inside. Staff wanted her transported to [hospital]...Staff stated because she left without permission.”

Highlighting the fact that police are often asked to intervene when a behavioral health response would be more appropriate, the third most common reason for a law enforcement call was “Mental Health/Medical.” This category also encompasses a wide range of calls, such as hospital transport, attempted suicide, welfare check, mental problem, safety check, emotional problem, and anything medically related. Upon review, many of the other categories contained calls that would better be reported here. Law enforcement is frequently called to respond to a behavioral health issue in a therapeutic residential program, when it would often be more appropriate to utilize crisis services, if the situation cannot be safely handled by the residential programs being funded to provide behavioral health services.

In one example, staff called law enforcement to intervene due to the residential program not providing enough staff.

“2-3 male juveniles being violent on the crisis side of the facility; caller did not have much information, not sure if anyone has been physically assaulted; only have 2 staff on that side of the building and they are not able to manage them.”

This example relates directly to the staffing problem that exists throughout behavioral health services for youth in Maine, at every level. Much has been said about this “workforce crisis.” Although that conversation is beyond the scope of this report, DRM agrees that it is a significant problem that must be addressed, but not by utilizing law enforcement to compensate for staffing shortages.

These examples are representative, and they illustrate the problem of law enforcement being asked to preserve order in a therapeutic setting. The residential programs are staffed with individuals who are required to be trained and qualified to treat youth with diagnoses including but not limited to autism, intellectual disability, mood disorders, post-traumatic stress disorder, and depression. When symptoms of these disabilities arise, the system is designed so that in all but the most extreme cases, the youth is in the setting best suited to

provide an appropriate response. Instead, all too often, these programs are turning to law enforcement personnel.

When law enforcement is called to a residential program, the situation becomes immediately escalated. The arrival of law enforcement is often very disruptive to the program; the youth may incur criminal charges; and law enforcement resources become further stretched. This host of problematic potential consequences could and should be avoided by treatment providers using de-escalation techniques. The records DRM reviewed contained multiple examples of residential program providers attempting to use law enforcement to respond to a behavioral health crisis.

Calls to Law Enforcement per Residential Program

After DRM removed records unrelated to youth from the data set, there were 815 calls to law enforcement from residential programs documented in law enforcement records over the 13 months for which data was collected. As indicated in Figure 2, there was significant variability among residential providers and the rates at which they called law enforcement. In Figure 2, all facilities run by a single provider have been grouped together to get a referral rate. Again, DRM assumed maximum capacity when calculating these rates, even though the programs do not regularly operate at capacity.

Figure 2 (Timeframe: January 1, 2016-January 31, 2017)

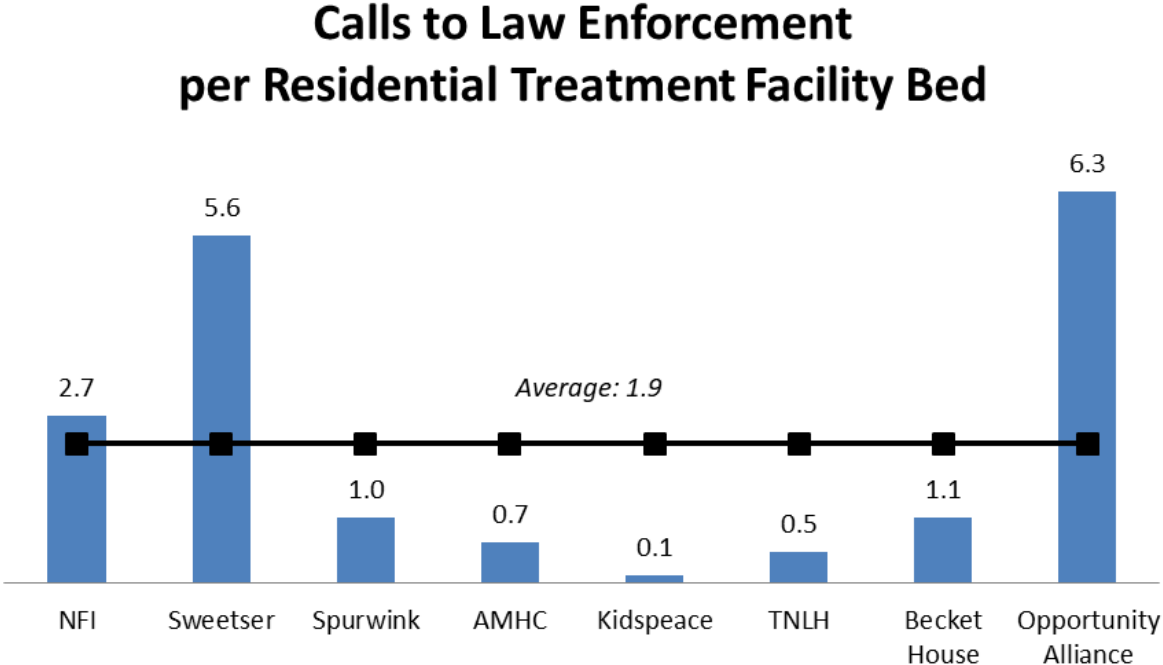


Figure 3 provides more detailed information for providers with more than one residential program. The capacity for each program is listed alongside the law enforcement agencies with jurisdiction, and the total number of calls to law enforcement during the 13 month period covered by this report.

Figure 3 (Timeframe: January 1, 2016-January 31, 2017)

Agency	Facility	Responding Law Enforcement Agency	Maximum Capacity	Juvenile-Related Calls to LE
AMHC	Calais	Washington SO & MSP	20	13
Becket House	Auburn	Auburn PD	8	24
Becket House	Belgrade	Kennebec SO & MSP	14	8
Becket House	Lewiston	Lewiston PD	8	2
Becket House	Litchfield	Kennebec SO & MSP	10	8
Kidspeace	Graham Lake Campus	Ellsworth PD	44	5
NFI	Beacon House	Buxton PD	8	23
NFI	Bridge Crossing	Bridgton PD	10	1
NFI	Oliver Place	Bath PD	6	13
NFI	Sidney Riverbend	Kennebec SO & MSP	8	33
NFI	Stetson Ranch	Penobscot SO & MSP	8	43
NFI	Summit View	Bangor PD	6	11
Opportunity Alliance	Edgewood	Scarborough PD	6	38
Spurwink	Brunswick	Brunswick PD	12	21
Spurwink	Casco	Cumberland SO & MSP	12	10
Spurwink	Chelsea	Kennebec SO & MSP	16	12
Spurwink	Cornville	Somerset SO & MSP	12	20
Spurwink	Lewiston	Lewiston PD	12	4
Sweetser	Belfast	Belfast PD	23	116
Sweetser	Hampden	Hampden PD	8	72
Sweetser	Rockport	Rockport PD	8	26
Sweetser	Saco	Saco PD	46	265
Sweetser	Winterport	Waldo SO & MSP	8	44
The Northern Lighthouse	The Northern Lighthouse Residential	Aroostook SO & MSP	6	3

As illustrated above, there was significant variability in the rate of calls from provider to provider, and also variability among each provider's individual programs. More input is needed from residential providers as to what specific challenges they face, and what factors may be influencing the variability in their calls to law enforcement. Potential factors may include setting (rural versus urban), characteristics of client population, treatment approaches, access to mobile crisis services, and others. This report is intended to highlight the information currently available, and provide a starting point for further discussion, information-sharing, analysis, and ultimately collaborative problem solving.

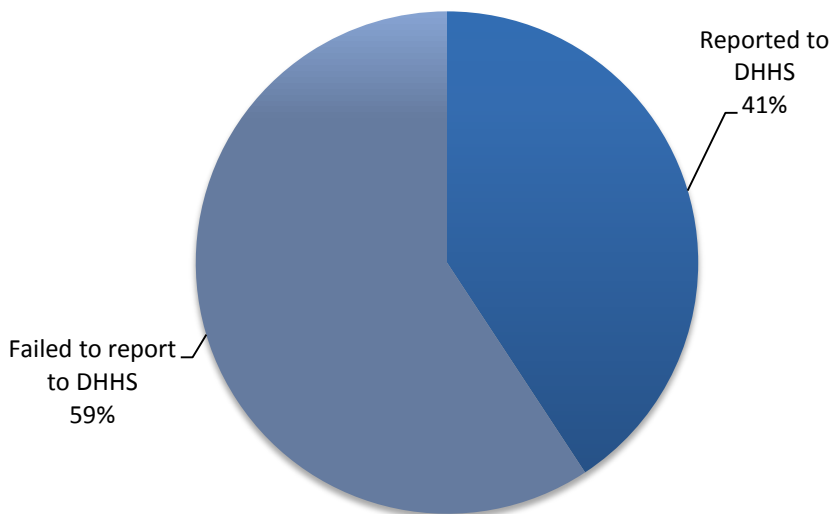
Although DRM believes the data contained herein highlights opportunities for improvement, it is important to note that residential providers are not only essential to the care of Maine's most vulnerable youth, but have great expertise in that field. This expertise will be needed in the process of strengthening the existing system.

Reporting Rates of Law Enforcement Calls to DHHS

DRM cross-referenced the data received from law enforcement with Reportable Events obtained from DHHS, and concluded that the majority (59%) of law enforcement calls did not have a corresponding Reportable Event to DHHS.

Figure 4

Residential Provider Reporting Rate for Calls to Law Enforcement



It is important to note one potential limitation with the data in this context. In working to link specific law enforcement records to specific reportable events, DRM was unable to connect 483 of the 815 individual law enforcement records to a reportable event to DHHS. This is how DRM calculated a failure to report rate of 59% state-wide. However, there were also 183 reportable events that DRM was unable to link to specific law enforcement records. For this report, we have excluded these “extra” reportable events from the analysis, even though it indicates that the total calls to law enforcement were likely higher than DRM has reported. But for

purposes of this discussion, even assuming that all of these “extra” reportable events corresponded to a specific law enforcement record, the failure to report rate state-wide would be 37%.

Whether the rate is 59%, or 37%, or somewhere in between, the failure of residential providers to accurately report to DHHS their use of law enforcement is problematic. By contract, DHHS has an oversight role with regard to the services delivered to youth in residential facilities. The function of the Reportable Event system is to notify DHHS of pre-designated types of incidents that require follow up and may necessitate technical assistance. This is an accountability measure, and also allows DHHS to collect data that can then be used to identify areas of improvement that are needed within the system. Without that data, effective reforms become more unlikely.

Recommendations

The conversation about the issues touched upon here – namely, the failure of the behavioral health system to appropriately and effectively treat all youth with disabilities, leading to over-reliance on law enforcement and the juvenile correctional system – has been ongoing in Maine for some time. DRM has received calls from DOC personnel at Long Creek and within the JCCO¹⁹ system, raising concerns about the prevalence of youth with disabilities who are correctionally involved. This issue has been discussed with stakeholders, including DHHS, residential providers, advocates, youth, and families. Although DRM is the first to gather the statewide data included in this report, this is the continuation of an ongoing effort to address this persistent issue.

There are some efforts already underway to begin addressing these issues. For instance, in Belfast, the DOC and Sweetser brought key stakeholders together to begin reviewing data and the issues that often lead to law enforcement calls for youth within the residential program. DRM commends DOC and Sweetser’s efforts in this region, and recommends the replication of that model in other parts of the state.²⁰ DRM offers the following additional recommendations:

1. Residential programs should develop appropriate individualized and therapeutic interventions and protocols to avoid calling law enforcement to respond to a behavioral health crisis. This would include the use of mobile crisis services. DHHS should provide oversight to ensure that law enforcement is truly used sparingly, as a last resort.
2. DHHS should engage in further inquiry into the reasons that residential providers would call law enforcement instead of mobile crisis when there is a behavioral health emergency. Conclusions should be shared with stakeholders, and a plan put in place to address the issues that are

¹⁹ Juvenile Community Corrections Officer. <https://www1.maine.gov/corrections/juvenile/Community/index.htm>

²⁰ This type of collaborative approach has also been designed in York County, which utilizes a Jurisdictional Team Planning (“JTP”) Group and a York County JTP Case Review Team. See “An Improved Police Response to Juveniles in Crisis: A Collaborative Approach,” Appendices D and E, Jonathan J. Shapiro, 2011, available at http://www.iacpyouth.org/Portals/0/Content_Files/An%20Improved%20Police%20Response%20to%20Juveniles%20in%20Crisis.pdf.

uncovered. See Appendix for useful research on best practices in utilizing a statewide crisis system.

3. Each residential program should have policies and practices in place to analyze specific incidents and trends that lead to calls to law enforcement. This should generate feedback and training to staff to avoid future calls to law enforcement, and to increase the quality of the therapeutic response to challenging situations.
4. Law enforcement agencies should work with residential providers to develop Memoranda of Understanding (MOUs) to clearly identify the types of incidents that warrant a law enforcement response. One area to look for models in this regard is the school context, where advocates have sought to reduce the negative impacts of increased police presence in schools through the use of MOUs to clearly delineate the role of school resource officers. This ensures that they are focused on significant safety risks instead of policing classroom misbehavior.
5. DHHS and DOC should cooperate to complete an updated study of youth committed to Long Creek for FY 2017.
6. DHHS should place restrictions on the ability of residential programs to discharge youth who are detained at Long Creek. Providers should be required to remain engaged in treatment planning, and planning for the youth's return to a treatment setting, unless and until the youth is committed. During this process, the residential program should hold the bed with an explicit right to return.²¹
7. DHHS, DOC, and other stakeholders should work together to enhance or create community alternatives to incarceration for youth arrested at residential programs.

²¹ It is worth noting that residential programs also discharge youth to emergency departments and psychiatric hospitals. This practice, too, is problematic and worthy of further exploration and reform. If a particular setting is determined not to be appropriate for a youth, they should be moved to an appropriate setting through careful discharge planning, instead of using law enforcement to bring about a discharge to a psychiatric hospital or correctional facility.

8. Municipalities and the state should increase training for law enforcement officers who are asked to intervene in a youth behavioral health crisis. One useful resource within the state is the Mental Health First Aid training offered by NAMI Maine.²² Law Enforcement agencies should also consider adopting the “Police Juvenile Reporting Form” that is used by the Maine State Police in York County.²³ Another promising model to explore is the CIT-Y protocol, described in further detail in the Appendix.

²² See <http://www.namimaine.org/?page=MHFA>.

²³ See “An Improved Police Response to Juveniles in Crisis: A Collaborative Approach,” Appendix B, Jonathan J. Shapiro, 2011, *available at* http://www.iacpyouth.org/Portals/0/Content_Files/An%20Improved%20Police%20Response%20to%20Juveniles%20in%20Crisis.pdf.

Appendix

Here in Maine, Troop A of the Maine State Police (York County) has already explored significant reforms regarding treatment of youth in a behavioral health crisis. Recognizing that the typical law enforcement response to such a call was often inadequate, Sergeant Jonathan Shapiro developed “An Improved Police Response to Juveniles in Crisis.”²⁴ The five components are additional police training; the creation of a centralized form to track and pass along information from these calls; a collaboration with crisis services to follow up with callers; a case review committee; and education for parents and caregivers.²⁵ This process promotes early identification of youth who require more supports, and facilitates the provision of the appropriate services, thereby avoiding further use of law enforcement for a behavioral health crisis.

Although this protocol generally presumes that the calls to law enforcement are made by parents of children who reside in the family home, there are elements that would be useful in the residential treatment context as well. For instance, the protocol provides guidance to callers on “information on the differentiation between situations that requires [sic] police intervention versus a non-crisis mental health intervention.”²⁶ The consistent utilization by law enforcement of the “Police Juvenile Reporting Form”²⁷ would likely be beneficial for youth in residential programs as well.

Maine is not the only place faced with these challenges. Below are examples of how other jurisdictions have worked to reduce unnecessary police involvement in residential settings.

Massachusetts has a Mobile Crisis Intervention Program, which is part of the Children’s Behavioral Health Initiative.²⁸ This program is available to providers 24

²⁴ “An Improved Police Response to Juveniles in Crisis: A Collaborative Approach,” Jonathan J. Shapiro, 2011, available at http://www.iacpyouth.org/Portals/0/Content_Files/An%20Improved%20Police%20Response%20to%20Juveniles%20in%20Crisis.pdf.

²⁵ *Id.* at 7.

²⁶ *Id.* at 13.

²⁷ *Id.* at Appendix B.

²⁸ Children’s Behavioral Health Initiative Mobile Crisis Intervention Practice Guidelines, 1/2015. Available at <http://www.mass.gov/eohhs/docs/masshealth/cbhi/practice-guidelines-mci.doc>

hours a day, 365 days a year. Providers can call and request that trained staff come to a program, in situations where immediate intervention is needed.

A similar program utilized in other states is the Crisis Intervention Teams (“CIT”) model,²⁹ which focuses on front-end diversion. This program trains staff on mental illness, primarily among the adult population. In 40 hours of intensive training, police officers are trained on mental illness, how best to respond to phone calls, and resources that can be used. “Studies of CIT programs indicate that they decrease the need for more intensive and costly law enforcement responses, reduce officer injuries, and increase referrals to emergency health care.”³⁰

Currently there is no parallel program for youth with mental illness. However, the National Center for Mental Health and Juvenile Justice recently proposed a set of reforms³¹ that included Crisis Intervention Teams for Youth (“CIT-Y”). With this program, police would be trained in signs and symptoms of youth with mental illness, and learn how to connect the youth with emergency mental health services or refer the youth for screening and evaluation. The proposed CIT-Y training program includes seven components.³² With the relevant Maine statutes³³ in mind, DRM recommends exploring the creation of a program such as CIT-Y.

In 2015, California passed a statute to address a related issue.³⁴ The aim of AB 388 was to “protect children and youth from being arrested and having charges filed against them due to minor incidents at group homes, and from being needlessly detained in juvenile halls solely due to their foster care status.”³⁵ This bill characterizes “minor incidents” as “fights among peers, conflict with group home

²⁹ “Law-Enforcement Based Diversion,” National Center for Mental Health and Juvenile Justice, 2012. Available at <https://www.ncmhjj.com/wp-content/uploads/2013/07/CIT-Y-Brief-2012.pdf>).

³⁰ “Law-Enforcement Based Diversion,” National Center for Mental Health and Juvenile Justice, 2012, page 3 (available at <https://www.ncmhjj.com/wp-content/uploads/2013/07/CIT-Y-Brief-2012.pdf>).

³¹ Models for Change- Systems Reform for Juvenile Justice; Law Enforcement-Based Diversion (Sept. 2012).

³² The modules include: Introduction, Adolescent Development, Adolescent Psychiatric Disorders and Treatment Interventions, Crisis Intervention and De-Escalation Techniques, Family Experience, Legal Issues, and Connecting to Resources.

³³ Maine Criminal Code 17-A M.R.S. §§ 15-16; Maine Juvenile Code 15 M.R.S. §§ 3201, 3203-A.

³⁴ Delinquency Filings for Group Home Incidents; Assembly Bill No. 388, CHAPTER 760, “An act to amend Section 1536 of, and to add Section 1538.7 to, the Health and Safety Code, and to amend Sections 241.1, 635, 636, 730.6, 4096.5, and 11469 of the Welfare and Institutions Code, relating to juveniles”, available at: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140AB388

³⁵ *Id.*

staff, destruction of property, etc.”³⁶ When a delinquency petition is filed based on allegedly unlawful conduct by a youth in foster care at a group home, this bill requires the juvenile court to determine whether the petition should be dismissed. Instead of through a criminal proceeding, the incident would be addressed through the group home’s internal therapeutic and behavioral management program, or through a change in placement to a facility better suited to meet the foster youth’s needs.

Another approach is to fundamentally change the system. The Coalition of Juvenile Justice recommends an infrastructure of community-based programs and systems to ensure direct access to a seamless, comprehensive and non-judicial continuum of care. These service providers would be empowered and resourced to respond to behaviors that might otherwise be labeled as status offenses.³⁷

Australia is currently working to reduce reliance on residential care and to transform it from a long-term placement option into a short-term.³⁸ Further, to improve support and training for care workers, the government has set aside significant resources to provide mandated minimum qualification training for residential workers and increase staffing levels per facility.

New South Wales has an initiative which is based on the principles of trauma informed care.³⁹ The first objective is to reduce the frequency of police involvement, by ensuring police calls are made only in appropriate circumstances, not for minor misconduct. The New South Wales program contains several targeted interventions towards this objective: developing tailored individual support plans for each resident; only calling the police when there is an immediate threat of danger to staff or other residents, or after receiving approval from a supervisor; and, lastly, requiring that when police are called they are given relevant details of the youth’s individual circumstances. The second objective is

³⁶ Delinquency Filings for Group Home Incidents; Assembly Bill No. 388, CHAPTER 760, “An act to amend Section 1536 of, and to add Section 1538.7 to, the Health and Safety Code, and to amend Sections 241.1, 635, 636, 730.6, 4096.5, and 11469 of the Welfare and Institutions Code, relating to juveniles”, available at: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140AB388.

³⁷ Infrastructure of Community-based Programs, Section 4.2 Available at <https://www.juvjustice.org/our-work/safety-opportunity-and-success-project/national-standards/section-iv-recommendations-pol-10#main-content>

³⁸ “Care Not Custody”, Victoria Legal Aid, 2016. Available at <https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-care-not-custody-report.pdf>

³⁹ *Id.*, page 25.

to promote the principle that criminal charges against a young person in residential care will not be pursued if there is an alternative and appropriate means of dealing with the matter—arrest should be viewed as a “last resort.”

In Pennsylvania, the Models for Change Initiative includes a guide to “Pre-Adjudication Diversion Policy and Practice,”⁴⁰ “a blueprint for creating a model system that responds appropriately to youth with mental health needs who may or do become involved with the juvenile court.”⁴¹ This system focuses on pre-adjudication diversion, with the mission to direct youth to a treatment program, when appropriate, instead of incarceration. Additionally, the Pennsylvania Juvenile Act and Rules of Juvenile Court provide for pre-adjudication diversion.⁴² The system includes many pre-adjudication intervention strategies, such as training of an intake probation officer “to enable them to recognize signs and symptoms of mental illnesses, substance abuse disorders, and developmental disabilities. Written protocols about eligibility requirements and diversion programs available in the community should be developed to provide an objective, consistent framework to guide probation officers in making referrals/recommendations to the court.”

⁴⁰ See: http://jlc.org/sites/default/files/publication_pdfs/Pre-Adjudication_Diversion_Policy_Guide2.pdf.

⁴¹ “The Joint Policy Statement, promulgated as part of Pennsylvania’s participation in the Models for Change systems reform initiative, sets out a vision of a comprehensive model system that: (1) prevents unnecessary involvement of youth who are in need of mental health treatment, including those with co-occurring substance abuse disorders, in the juvenile justice system; (2) allows for the early identification of youth in the system with mental health needs and co-occurring disorders; and (3) provides for timely access by identified youth in the system to appropriate treatment within the least restrictive setting that is consistent with public safety needs.” *Id.*

⁴² See: 42 Pa. Cons. Stat. Sec. 6323; 42 Pa. Cons. Stat. Sec. 634 and Rule 370; 42 Pa. Cons. Stat. Sec. 6341b and Rule 409(b); 42 Pa. Cons. Stat. Sec. 1520.