Investing in Youth
Not Incarceration

A Toolkit for Creating a Community-Led Approach to Youth Mental Health

do social justice.
NJISJ NEW JERSEY INSTITUTE FOR SOCIAL JUSTICE

Salvation and Social Justice
Liberating Public Policy Theologically

Introduction

New Jersey's youth justice system is fundamentally broken.

Our state has the worst Black to white youth incarceration disparity rate in the nation – with Black youth almost 18 times more likely to be locked up than their white counterparts[1] – even though Black and white youth commit most offenses at similar rates.[2] This system does not increase public safety, with over a quarter of young people released from our state's youth facilities returning to them within three years.[3] And this racialized youth incarceration system comes at an exorbitant cost: this year, New Jersey will spend $445,504 to incarcerate each young person within its three youth prisons.[4] And this cost comes at a time when youth prisons are over 83% empty[5] yet staffed as if at full capacity.[6] Notably, in May 2021, Hayes, the state's girls' youth prison, only had two incarcerated girls.[7]

Imagine if New Jersey invested $445,504 toward reducing each youth's risk factors instead of toward their incarceration. Such an investment could allow their families to purchase a home, reduce or eliminate food insecurity or give their child a fully funded education at Princeton University.[8]

Beyond money, youth incarceration has another, more tragic, cost – the mental health toll it takes on our incarcerated youth. Nearly 25% of New Jersey's justice-involved youth admitted in 2018 to the Juvenile Medium Security Facility – the state's most secure youth prison for boys – had a pre-existing mental health diagnosis.[9] Seventy percent of New Jersey's young people committed to adult prisons in 2018 had a mental health diagnosis.[10] Studies show that incarceration aggravates mental health issues in youth.[11] Incarcerated youth with mental health issues are also more likely to attempt suicide, recidivate and develop substance abuse issues than their peers.[12] Despite these concerns, New Jersey has failed to meaningfully invest in mental health treatment, resources and supports.

It also costs more to incarcerate youth with mental health issues. For example, research on California's youth justice system shows it costs approximately $18,800 more to house a youth with a mental illness than their peer without a diagnosis, and there is an average cost of $4,387 for psychotropic medication per stay.[13] The financial costs alone justify a transformation of this broken system.

By contrast, mental health care specifically geared toward youth who are justice system-involved has resulted in arrest decreases as high as 70% compared to those who do not receive such care.[14] There are also some protective factors, or supports that reduce the impact of negative experiences — like high self-esteem, resilient personality traits and strong social support — which, if increased, can mitigate delinquency.[15] If our state addresses mental health needs with well-funded mental health services on the front end, we may significantly reduce the number of young people entering the youth justice system.

To fundamentally transform New Jersey's broken youth justice system, the New Jersey Institute for Social Justice ("the Institute") launched the 150 Years is Enough Campaign in June 2017. The goals of the campaign are to close New Jersey's three youth prisons and to develop a well-funded and resourced community-based system of care. In furtherance of the campaign, we have created two toolkits to support community advocates in shaping what a well-funded community-based system of care can look like in their own neighborhoods. Last year, we released the first toolkit in our series, *Youth Justice Toolkit: A Community-Led Restorative Justice Approach*, which outlined the concepts of restorative justice and trauma-informed care to support the development of restorative justice hubs in the communities most impacted by youth incarceration.[16] The *Youth Justice Toolkit* served as the foundation for the recently passed Restorative and Transformative Justice for Youths and Communities Pilot Program Bill (A4663/S2924), which, when signed into law, will establish restorative justice hub pilot programs in Newark, Paterson, Trenton and Camden.[17] The bill will move $8.4 million away from incarceration and toward promoting services within the hubs that create healing and accountability in the communities where young people live.[18] The bill is currently awaiting signature by the governor.

This toolkit, *Investing in Youth, Not Incarceration*, will build upon our previous work by assessing how a community-based system of care can and must provide well-funded and resourced mental health supports for system-impacted youth. Based on the voices of 115 New Jersey residents, advocates and impacted people we interviewed, this toolkit will provide community-based solutions to the mental health crisis we are experiencing in our youth justice system. Relying on this vital feedback, our toolkit outlines a mental health component of the community-based system of care that can operate within the restorative justice hubs detailed in our previous toolkit. Specifically, this mental health component includes the following elements: (1) community cafés, (2) community accountability councils and (3) mental telehealth lines.

The Institute also encourages communities and their members who are outside the restorative justice hub framework to use this toolkit to create their own critically needed mental health services. Our aim is for this toolkit to serve as an important tool to activate communities across this state to ensure they are operating holistically in support of our youth.

This toolkit is divided into the following five sections:

I. What are the Community Perceptions of Mental Health Care?
II. Key Concepts and Definitions in Mental Health
III. What Does the Community-Based Continuum of Care Look Like?
IV. Adding Mental Health to Restorative Justice Hubs
       A. Community Cafés
            How to Create and Facilitate a Community Café
       B. Community Accountability Councils
            How to Create and Facilitate a Community Accountability Council
       C. Mental Telehealth Line
            i. How to Create a Mental Telehealth Line
            ii. Grant Example for a Mental Telehealth Line
            iii. Budget Sample for a Mental Telehealth Line
            iv. Sample Invitation for Provider to Participate in a Mental Telehealth Line
V. Indicators of Success

Between October 2020 and February 2021, the Institute assembled 115 community members, advocates and mental health professionals for community mental health sessions where they shared their perceptions of mental health care in their respective communities.[19] Participants also identified mental health care gaps that existed for children transitioning from jail or prison back into their community. The findings from these sessions were as follows:

Lack of Access

1. Families are often given appointment times that are months away from the time help is sought. A family's insurance status is sometimes a barrier and walk-in services are not available unless there is a life-threatening crisis associated with the visit.

2. Mental health services are not positioned in places people frequent and often require cross-town transportation, which can be a barrier for low-income families.

3. New Jersey's Children's System of Care[20] has exclusionary practices that only provide services to youth who have an open case in the Department of Children and Families (DCF). Families should not have to become system-involved to receive comprehensive multi-systemic care.

Lack of Accountability

1. Community members should hold mental health organizations accountable for the services they provide.

2. Mental health providers do not have a comprehensive outreach strategy to mitigate barriers and are not immersed in community events.

3. Mental health care is not taken as seriously as physical health care. Mental health issues should not progress to the level that an individual causes violence to themself or others before it is acknowledged as a health emergency.

Over-Reliance on the Justice System

Police officers have replaced social workers in responding to behavioral issues in schools, which begins the school to prison pipeline, reinforces cultural trauma[21] and makes unspoken associations between mental and behavioral health and criminality.

Stigma & Lack of Mental Health Information

1. Most identifiable mental health professionals are associated with school-based services. Community members were unable to identify more than four agencies in their communities, and information regarding referrals or accessing services was limited. The school to community continuum of care is so limited that there are students pursuing higher education with the sole purpose of accessing mental health care.

2. Mental health stigma is a huge barrier to accessible services. Mental health conversations in communities of color need to be normalized.

3. Lack of cultural competence and relatability in providers are barriers to care.

4. Communities use "mental health provider," "psychiatrist," "therapist" and "social worker" inter-changeably without full understanding of the variety of different mental health roles, where they can be found and what the best form of care is for a child's specific issues.

5. Extracurricular activities are used as an all-encompassing response to youth behavior. Without a mental health component, however, these types of programs are not as effective as one might think.

Overall, these findings support the need to transition funds away from incarceration and toward reinforcing the current mental health provisions in communities to service youth before they become system-involved. This toolkit will provide solutions to most of the findings presented above and provide a framework that defines an advocate's role in moving funds towards mental health care. Some of the issues stated above will require a more formal solution through policy recommendations to the New Jersey Legislature.[22]

II. Key Concepts and Definitions in Mental Health

According to the U.S. Department of Health and Human Services, **mental health** includes a person's psychological, emotional and social well-being and affects how a person feels, thinks and acts.[23] Mental disorders relate to issues or difficulties a person may experience with his or her psychological, emotional and social well-being.

There are numerous professionals that operate within the mental health space.[24] Understanding the different services these professionals provide can ensure that families are receiving the treatment and services that their young people need. Below is an overview of the most common mental health professionals that families may encounter.

- **Psychologists** are doctoral level professionals trained to evaluate a person's mental health using clinical interviews, psychological evaluations and testing. They can make diagnoses and provide individual and group therapy but cannot prescribe medication. They are often found in schools.

- **Psychiatrists** are medical doctors who perform some of the same functions as psychologists but are authorized to prescribe medications. These types of professionals often function as private practice therapists or are contracted by a school board to provide services to a district. This will usually require a referral from the school.

- Bachelor's level **social workers** provide case management, inpatient discharge planning services, placement services and other services to support healthy living and can be found in various community settings. **Masters and Doctoral Level social workers** are considered advanced professionals who have obtained clinical licensure, are trained to evaluate a person's mental health and use therapeutic techniques based on specific training programs. They are also trained in case management and advocacy services. These are the types of social workers who enter private practice or are found in a child's school.

- Although there are specific mental health fields that use the term **therapist**, like marriage and family therapists, the term therapist can accurately be used to define any of these mental health professionals.

There are also key concepts that should be present in all mental health care spaces, especially those situated in vulnerable communities.

- **Cultural competence**[25] is the cornerstone of social work practice. It is a concept grounded in one's ability to understand, appreciate and interact with people from **cultures** or belief systems different from their own. It also supports a mental health provider's awareness of one's bias and perception of the community with whom they are working. A practicing care provider must understand the value systems that underpin the behaviors of the clients with whom they are working. When there are communities who have an inherent mistrust of mental health services and professionals who are not representative of the community, it is imperative that the professionals exhibit high levels of cultural competence.

- There is no shortage of therapeutic frameworks that address adolescent behaviors; however, the **multisystemic team (MST) approach**[26] is considered one of the most effective. MST is a therapy that involves the support of parents, siblings, friends, religious figures, medical doctors and teachers. A practitioner can identify a young person's triggers, proactive relationships and resources and recommend solutions that fit into their lifestyle.

- **Telehealth** – sometimes called telemedicine – is the use of electronic information and telecommunication technologies to provide care when a client and their doctor are not in the same place at the same time.[27]

III. What Does the Community-Based Continuum of Care Look Like?

Within youth justice, the *community-based continuum of care* is a series of five levels of service that are often necessary to rehabilitate a justice-involved youth. The five levels are: prevention, pre-intervention, intervention, diversion and out of home & aftercare.[28] The traditional youth justice continuum of care often involves incarceration at one of the levels.[29] Restorative justice hubs can function on all five levels of the continuum, providing options that support youth in all stages of their journey outside of incarceration.[30]

Although there are numerous resources that support interventions that address risk factors (the social factors that place a young person at risk for incarceration), little is known about the efficacy of interventions that increase *protective factors* — the positive social supports that reduce the impact of risk factors. Providing mental health support, particularly within a restorative justice hub, could create a preventive layer of support for young people to help them avoid entering the youth justice system. We encourage mental health providers, program developers and community members to use this toolkit to explore increasing protective factors.

Given the close relationship between mental health and the youth justice system, New Jersey should redirect funds away from incarceration and towards mental health care. The resulting continuum would be more viable and financially responsible. Providing 40 youth with a high quality[31] MST team would cost New Jersey approximately $350,000 annually,[32] almost $100,000 less than incarcerating just one child per year. Even if all the 80 youth who are incarcerated at the time of this toolkit needed services,[33] two MST teams could service them all for a total cost of $700,000 annually (or $8,750 per youth) versus the approximately $53 million-dollar budget New Jersey's Juvenile Justice Commission spends to support incarceration.[34]

To create the proposed community-based continuum of care, funds should be diverted away from youth prisons and toward many of the other viable community-based options – like peer supports, MST intervention, restorative justice hubs and other mental health supports – that can tackle the root behavioral and social indicators that place young people at risk for incarceration.

IV. Adding Mental Health Services to Restorative Justice Hubs

In our previous *Youth Justice Toolkit*, we highlighted how restorative and transformative justice practices are necessary to support youth in their communities. The use of these practices, along with the mental health recommendations in this toolkit, would optimally be centered in a restorative justice hub – a central, safe space where at-risk youth can come to mitigate conflict and seek support. A hub also serves as a resource for youth who need additional support post-release from a secure facility. Even though these services can be used both in and outside the restorative justice hubs, below are several ways that mental health services can be added to restorative justice hubs:

A. Community Cafés

During the community listening sessions, community cafés were proposed as a solution to normalize mental health in conversations.

Community cafés are safe spaces for conversations, typically hosted by parents or community volunteers, that are intended to develop the relationships necessary to strengthen families and community resources. The cafés are used to discuss mental health concepts and concerns, share stories and swap resources or develop campaigns to create space to develop solutions. Cafés can be integrated into the community conferencing model already present in restorative justice hubs.[35]

How to Create and Facilitate a Community Café

- Determine what community partners are relevant to being on the planning team. Community partners should include mental health professionals that represent the community's available services and can also include faith leaders and school personnel.
- Develop a compelling invitation that considers the cultural components that are important for your audience.

- Co-create with parent volunteers a curriculum for the conversations and topics you want to explore with mental health professionals.
- Develop your list of tasks, needs and resources according to your budget. A sample budget is included below.
- Develop a *run of show*.
    ◦ A run of show is an order of events that will occur at the café. Cafés typically run about two hours and include icebreakers, rapport building, probing questions, debriefing and action items.
- Follow up.
    ◦ Discuss with the planning team what was learned, what went well and opportunities for growth. Gather and share all relevant information with the community and your partners.

B. Community Accountability Councils (CACs) are another (albeit indirect) way to introduce mental health services to hubs. In various community mental health sessions, CACs were a proposal to combat the lack of outreach and exclusionary policies held by some mental health offices. CACs develop community-based strategies to address public safety, verify availability of investments and resources and ensure the account-ability of elected officials and public servants. CACs are community-led and differ in function from Youth Service Commissions (YSCs) in that YSCs are state-mandated entities that plan, monitor and implement state-supported programs and services for youth, while CACs serve as an accountability agent, empowered by the community, to ensure that YSCs' actions are in line with the community's needs and services.

How to Create and Facilitate a CAC

- Have two or three members of the CAC serve as liaisons with mental health organizations in the community.
- Liaisons should compile a list of mental health organizations, qualifications for treatment and re-ferral processes. They will also help to identify barriers to effective outreach for organizations.
- Liaisons should build relationships with mental health professionals to garner their participation in community cafés and work to decrease social barriers to care.

C. Mental Telehealth Lines

Mental telehealth lines are yet another way that mental health services can be introduced to the re-storative justice hubs. Mental telehealth lines can be a useful tool in bringing life-saving mental health services to clients without the need for physical visits with counselors.

As the COVID-19 pandemic swept across our nation in March 2020, we saw a significant shift in what we considered "normal." Social distancing, quarantining and self-isolation were mandated actions for the better part of the year. New Jersey had a remarkable response to the pandemic with the introduction of accommodations like distance-learning, working from home and the stabilization of telehealth care.

These accommodations included virtual check-ups or wellness "visits," COVID-19 screening, urgent care and mental health services. However, access to a phone or electronic device with internet capabilities and health insurance were necessary to utilize these services. As a result, COVID-19 exposed critical cracks in New Jersey's structural foundation, one of those cracks being the *digital divide*. Essentially, the *digital divide* occurs when those with access to digital technology receive services and those without access to this technology do not receive services – resulting in negative outcomes. In August 2020, almost 231,000 students lacked the devices necessary for distance learning.[36] Although after a full pandemic year there have been efforts to target the K-12 *digital divide*, there are two major barriers reinforcing the divide in telehealth. The first barrier involves the lack of access to technology for opportunity youth,[37] those who are either homeless, disenrolled from school, have recently graduated or have no parental advocates. The second bar-rier involves the lack of access to medical insurance sufficient to provide access to youth mental telehealth.

Currently, suicide hotlines and telemedicine through mobile insurance applications are the primary ways to access mental health care when in-person care is inaccessible. However, uninsured youth should not have to wait until their mental health deteriorates to the point of suicidality before it can be addressed appropriately and insurance status should never be a barrier to care. The creation of a mental telehealth line that has full community oversight will provide immediate mental health care to young people as they need it while they wait for the availability of an appointment time with a community provider. Although New Jersey operates three mental telehealth lines including NJ Peer Recovery, the WarmLine and the NJ Mental Health Cares Helpline,[38] as well as the New Jersey Suicide Prevention Hopeline, there are two obstacles present that pose specific roadblocks to at-risk youth with mental health concerns. The first obstacle is that only one line operates 24/7. The second obstacle is that the training components lack cultural competence and the listed training components do not encompass critical race theory – a theory that analyzes the intersections of race and history to understand their worldview – or any cultural theory that pinpoints care for people of color.[39]

This toolkit will support the creation of a basic phone-only mental telehealth line that supports youth with or without insurance who need any level of care – regardless of suicidality or mental state. It will also provide sample letters and budgets to make advocacy easier.

How to Create a Mental Telehealth Line

The following are steps to create a fully functioning mental telehealth line housed in the restorative justice hubs:

1. **Identify one or two mental health professionals who will serve as a Mental Telehealth Line Program Coordinator.**

    The Mental Telehealth Line Program Coordinator will be held responsible for recruiting, scheduling and promoting the telehealth line. In lieu of hiring a new coordinator, an existing senior social worker employed by the restorative justice hub can have their position modified to incorporate these duties for an increase in pay.

2. **Identify a mental health training professional to serve as a part-time in-house trainer to provide ongoing professional development to telehealth line volunteers.**

3. **Identify a Mental Telehealth Line Manager.**

    a. The Mental Telehealth Line Manager will be responsible for maintaining the efficacy of the telehealth line, ensuring evaluation tools are being used properly and will serve as a mental telehealth line professional and coach volunteers on responding to calls.

4. Obtain Liability Insurance.

5. Identify the preferred phone line.

> a. Obtain an automatic call distribution system. Utilizing an automatic call distribution system (ACD) allows volunteers to answer calls live without the need to press 1 or 2 to get to the right person.

> b. Ideally, a Voice Over IP or internet-based phone line is the most cost-effective option; however, be sure to use a line that has call-forwarding capabilities to ensure that volunteers can answer calls at home or on their personal cellphones.

> c. Having a phone line with text capabilities may expand the scope of youth who will participate as well.

6. Recruit volunteers to staff the phone line.

> a. Having 12 volunteers commit to four-hour shifts on the 24-hour telehealth line should provide enough coverage to support community youth with mental telehealth services.

> b. Target Masters Programs for Psychiatry, Psychology and Social Work as there are typically internship hours that are required for completion of their programs.

> c. CAC mental health liaisons can also advocate for the integration of telehealth line requirements for the mental health interns at the organizations they connect with. The opportunity is also open for practicing, fully licensed mental health professionals.

> d. Although youth anonymity is guaranteed, youth should be offered the option to follow up with a provider in-person at either a community partner's organization or at their local restorative justice hub.

7. Conduct a full training on mental telehealth delivery that models national standards and includes culturally competent components.[40] A full training should include the following components:

> a. Critical Race Theory

> b. Trauma & Adverse Childhood Experiences

> c. Cultural Competence

> d. Addressing Bias

> e. Interpersonal Theory of Suicide

> f. Assessment Model (Standard for National Suicide Prevention Lifeline)

> g. Handling Difficult Callers / Handling Crisis Callers

> h. ASAM Levels of Care[41]

> i. UNCOPE Substance Abuse Screening Tool[42]

> j. Motivational Interviewing

> k. Understanding Developmental Disabilities

> l. Understanding Federal and State Government Entitlement Programs

8. Public Education

> a. Host a social media event to launch the telehealth line. This will give the community a chance to ask questions, generate conversation and begin outreach for the telehealth line.

> b. Ensure that all entities that service youth have a flyer, business card or, at a minimum, access to the phone number to share with their young people.

9. Evaluation

a. Have each volunteer complete a call log for each call, which can assist with identifying demographics such as race, age and gender, while also screening for mental health concerns and level of satisfaction with the service provided. Keeping these logs will help support the usefulness and effectiveness of the telehealth line, which can be helpful in the pursuit of continued funding.

b. Consider engaging the services of an external evaluator that can develop a pre- and post-intervention questionnaire that can shed light on the efficiency of your mental telehealth line. An external evaluator can most easily be found in your local college or university's psychology, psychiatry or social work department.

10. Self-care

Social work and mental health care have some of the highest turnover and burnout rates. Appropriate self-care activities, spaces to process and time to debrief are all critical components of self-care for volunteers. Providing small tokens of appreciation or certificates are also ways to support and show appreciation for the telehealth line volunteers.

Grant Example for Mental Telehealth Line

Using the statistics and information provided in this toolkit for framing, community members interested in creating a mental telehealth line are encouraged to use the grant example template provided in the *Youth Justice Toolkit: A Community Led-Approach to Restorative Justice* – a link to which can be found in the resources section.[43]

Budget Template for Mental Telehealth Line

Position or Expense Category	% Of full time	Budget	Restorative Justice Hub	Admin.	Fund-raising	Total
Personnel						
Full Time						
Enter Fringe Rate for FT Staff Here:	23.0%					
			%	%	%	
Telehealth line Coordinator	100%	$ -	50%	30%	20%	100%
Telehealth Line Manager						
Total Full Time Salaries/Wages		$ -	$ -	$ -	$ -	100%
Total Full Time Fringe		$ -	$ -	$ -	$ -	0%
Part Time						
Volunteers (12)	100%	$ -	25%	10%		100%
Mental Health Training Professional						
Total Part Time Salaries/Wages		$ -	$ -	$ -	$ -	100%
Total Part Time Fringe	12.0%	$ -	$ -	$ -	$ -	0%
TOTAL SALARIES/WAGES		$ -	$ -	$ -	$ -	
Voice Over IP (VoIP) Phone Service		$ -	$ -			0%
Cell Phones		$ -	$ -			0%
Program Materials		$ -	$ -			0%
Mental Health First Aid Training		$ -	$ -			0%
Communication Plan costs: Social Media, Print, etc.		$ -	$ -			0%
Technical (IT) Support		$ -	$ -			0%
Automatic Call Distribution System		$ -	$ -			0%
Toll-free Phone Number		$ -	$ -			0%
Program Evaluation		$ -				0%
Liability Insurance		$ -				0%
Total Specific Expenses		$ -	$ -	$ -	$ -	0%
Total Non-Personnel / OTPS Costs		$ -	$ -	$ -	$ -	0%

Sample Invitation for Provider to Participate in Mental Telehealth Line

Dear XXX,

Youth justice transformation is not a new issue in New Jersey. For years, advocates have been calling for an end to the wasteful and ineffective incarceration practices that do nothing to rehabilitate youth and show stark racial and economic disparities. Most notably, for the past four years, New Jersey has been repeatedly asked to invest in our youth and not incarceration. However, even as the youth prison population declines, the cost to incarcerate our young people continues to rise.

New Jersey's youth justice system is inherently flawed in the most dangerous ways. Black children are almost 18 more likely to be incarcerated than their white counterparts, even though they commit most crimes at similar rates. Nationally, 70% of incarcerated young people have a mental health diagnosis, and New Jersey leans into this practice with almost a quarter of youth admitted in 2018 to the Juvenile Medium Security Facility – the state's most secure youth prison for boys – having a mental health diagnosis.

Incarceration is not mental health care. The experiences from impacted people support this fact:
- There is no mental health care continuity that supports reintegration of youth back into their communities post-release.
- Wait times to receive personalized care are excessive. Some respondents reported wait times as long as six months.
- Representation matters. Mental health care providers lack diversity in staff which poses a barrier to accessing and trusting care.
- Mental health is not taken as seriously as physical health care. Mental health becomes prioritized once it escalates to suicidality – a practice that needs to end.

We cannot continue to ignore the service gaps in communities that leave our children defenseless against their own mental state and systems that disproportionately target them.

Although the push for the New Jersey Legislature to support legislation that closes these antiquated institutions is still underway, we cannot continue to wait for that investment in our youth. That job will fall to us.

To adequately address the devastating relationship between mental health care and youth incarceration, we are establishing a mental telehealth line that will provide youth with 24-hour access to a mental health support person without having to be in crisis. Although we are seeking mental health providers that share social experiences with community members, we welcome any provider because this mental telehealth line will be grounded in cultural competence and critical race theory.

Given your role as a mental health service provider, we invite you to help us close these gaps by volunteering in our community-led response to mental health care. A volunteer from your organization can be (1) a licensed mental health professional, regardless of specialization, or (2) a masters-level intern servicing your organization.

We ask that all volunteers do the following:

1. Agree to commit to a virtual training before being assigned to the telehealth line.

2. Commit to at least one four-hour shift per week.

3. Optional: Follow up with interested callers for in-person appointments at (enter name of your Restorative Justice Hub).

If you are interested in joining us in launching this initiative or have any questions, please feel free to contact me at (insert email address and/or phone number). We also welcome you to learn more about (name of your restorative justice hub) by visiting us for a Community Café. Our next one will be held at TIME on MM/DD/YY at ADDRESS. We look forward to moving this critical work forward with you.

Respectfully,
XXX

Should restorative justice hubs or communities implement any of these suggested programs, there will be several indicators of success:

1. For Community Cafés, success involves an increased number of community partners, youth and parents involved in the community cafés.

    a. Normalizing conversations and dispelling myths regarding mental health is a crucial first step in reducing the stigma mental health has in communities of color.

    b. Each community café session should have a minimum of 12 participants to be considered functioning.

2. Community Accountability Councils have several indicators of success:

    a. Any mental telehealth questionnaires should reflect that people are increasingly learning about their mental health options.

    b. Regular meetings with community mental health providers occur to build and maintain relationships, communicate difficulties in outreach and gain insight on services available to community members.

    c. Significant increase in outreach being done by service providers, as well as increased visibility of sevice providers at community events and school functions.

3. For the Mental Telehealth Line, an indicator of success is an increased number of youth and families seeking mental health support at a restorative justice hub. The more youth and families who seek these services, the more opportunities there will be for them to meaningfully engage with their treatment.

    a. The number of calls to a Mental Telehealth Line should be noted.

    b. More intricate data should be measured using pre- and post- session questionnaires for anyone seeking mental health support or referrals at the Restorative Justice Hubs and/or via the telehealth line.

    c. The needs of the family should be measured. The steps the family took before seeking help at the restorative justice hub or on the Mental Telehealth Line should be noted and then followed up with a measure of their level of satisfaction with the services provided.

    d. Pre- and post- service questionnaires that measure increased knowledge around their specific mental health concern should be asked. The youth and their family should be asked whether they feel more equipped to navigate community resources. Perceptions regarding the lack of access to mental health treatment from the community should be decreasing.

Resources

1. **Community Cafés -** www.thecommunitycafe.org

2. **Youth Justice Toolkit: A Community Led Restorative Justice Approach -** bit.ly/YJToolkitNJISJ

3. **NJ Mental Health Cares -** https://www.njmentalhealthcares.org/

4. **The New Jersey Crisis Intervention Response Network -** (609) 394-3600

5. **New Jersey Suicide Prevention HopeLine -** https://njhopeline.com/

6. **National Suicide Prevention Hotline -** 800-273-8255

7. **Alliance for Educational Justice -** https://wecametolearn.com/?fbclid=IwAR2tFj6lSlv5LEE_TmUC-CLuAPmYswLu4heyQsDhcployr0wL0O0gwrWxOHA

8. **Field Guide – Setting Up a Hotline -** https://pdf.usaid.gov/pdf_docs/PNACU541.pdf

9. **Questions for Psychologists Regarding the Closure of Youth Prisons: A Literature Review by Dr. Jemour Maddux –** https://d3n8a8pro7vhmx.cloudfront.net/njisj/pages/691/attachments/original/1621953821/Maddux_Final_LitRev.pdf?1621953821

Acknowledgements

Endnotes

[1] *Easy Access to the Census of Juveniles in Residential Placement: 1997-2019, Race/Ethnicity by State 2019 (Rate per 100,000 Juveniles)*, OJJDP (July 19, 2021), https://www.ojjdp.gov/ojstatbb/ezacjrp/asp/State_Race.asp?state=58&topic=State_Race&year=2019&percent=rate&maps=no.

[2] Joshua Rovner, The Sentencing Project, Racial Disparities in Youth Commitments and Arrests (2016), https://www.sentencingproject.org/publications/racial-disparities-in-youth-commitments-and-arrests/.

[3] N.J. Dep't of Corr. et al., Release Cohort Outcome Report: A Three-Year Follow Up 3 (2015), https://www.state.nj.us/corrections/pdf/offender_statistics/2015_Release_Recidivism_Report.pdf.

[4] Off. of Mgmt. & Budget, The Governor's FY2022 Detailed Budget D265 (2021).

[5] *Id.* (showing that the institutional operational capacity is 465); Email from Sharon Lauchaire, Chief of Pub. Relations, N.J. Juv. Just. Comm'r to Yannick Wood (May 13, 2021 10:16EST) (on file with author) (showing that as of May 6, 2021, there were only 80 committed youth). This is approximately 17% of the 465-youth capacity therefore, the facilities are approximately 83% empty.

[6] Off. Of Mgmt. & Budget, *supra* note 4 at D265 (showing that in 2021, there were 346 filled positions for Institutional Control and Supervision and there were 171 filled positions for Institutional Care and Treatment for a total of 517 positions in youth institutions for incarceration); *Id.* (representing that in 2019, the average population was 172, there were 358 and 190 filled positions for Institutional Control and Supervision and Institutional Care and Treatment, respectively for a total of 548 positions). The average population in 2019 is approximately twice the current population of 80.

[7] Email from Sharon Lauchaire, *supra* note 5.

[8] Adam Clark, *The 27 Most (and Least) Expensive Colleges in N.J.*, NJ.com, (Sept. 24, 2019), https://www.nj.com/news/g66l-2019/01/dec-c3936ef2662/the-27-most-and-least-expensiv.html.

[9] N.J. Juvenile Justice Comm'n, Youth Admitted to JMSF, 2018 2 (2019) (unpublished) (on file with Andrea McChristian).

[10] N.J. Parents Caucus, The Incarceration of Children and Youth in New Jersey's Adult Prison System 13 (2021), http://newjerseyparentscaucus.org/wp-content/uploads/2018/10/NJPC-The-Incarceration-of-Children-and-Youth-in-NJ-Adult-Prison-System.pdf.

[11] Off. of Juv. Just. & Delinq. Prevention, Literature Review a Product of the Model Programs Guide 4 (2017), https://ojjdp.ojp.gov/mpg/literature-review/mental-health-juvenile-justice-system.pdf.

[12] Jemour A. Maddux, Questions for Psychologists Regarding the Closure of Youth Prisons: A Literature Review 2 (2021), https://d3n8a8pro7vhmx.cloudfront.net/njisj/pages/691/attachments/original/1621953821/Maddux_Final_LitRev.pdf?1621953821.

[13] *Id.* at 2.

[14] Lee A. Underwood & Aryssa Washington, *Mental Illness and Juvenile Offenders*, 13 Int. J. Envtl. Res. & Pub. Health Psych. 228 (2016), https://www.mdpi.com/1660-4601/13/2/228/htm.

[15] Maddux, *supra* note 12 at 7.

[16] N.J. Inst. For Soc. Just., Youth Justice Toolkit: A Community Led Restorative Justice Approach (2020), https://d3n8a8pro7vhmx.cloudfront.net/njisj/pages/1427/attachments/original/1595600849/Youth_Justice_Toolkit_Final.pdf?1595600849.

[17] A.B. 4663, 219th Leg., (N.J. 2020); S.B. 2924, 219th Leg., (N.J. 2020).

[18] *Id.*

[19] Sessions were held in Camden, Trenton, Newark, Paterson, Jersey City, Elizabeth, Winslow area, Ewing area, Maplewood Area, Clifton-Teaneck area and Bordentown area.

[20] DCF's Children's System of Care (CSOC), formerly the Division of Child Behavioral Health Services, serves children and adolescents with emotional and behavioral health care challenges and their families, children with developmental and intellectual disabilities and their families and children with substance use challenges and their families. CSOC is committed to providing services based on the needs of the child and family in a family-centered, community-based environment.

[21] Cultural trauma occurs when an entire culture experiences a historical, geographical event caused by the same persons or events. Jeffrey C. Alexander et al., Cultural Trauma and Collective Identity 61 (Univ. of Cal. Press 1st ed. 2004).

[22] *See* N.J. Inst. For Social Just. Costs of Incarceration (2021 forthcoming).

[23] Off. of Juv. Just. & Delinq. Prevention, *supra* note 11, at 1.

[24] *Types of Mental Health Professionals*, National Alliance on Mental Illness (June 1, 2021), https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals.

[25] Tori DeAngelis, *In Search of Cultural Competence*, 46 Am. Psych. Ass'n Monitor on Psych. 64, 64 (Mar. 2015), https://www.apa.org/monitor/2015/03/cultural-competence.

[26] Joan G. Lesser & Marlene G. Cooper, Clinical Social Work Practice: An Integrated Approach 204-219 (Pearson ed. 5th ed. 2015).

[27] *What is Telehealth?*, Telehealth.HHS.gov (June 2, 2021), https://telehealth.hhs.gov/patients/understanding-telehealth/.

[28] *Continuum of Care*, N.J. Inst. For Soc. Just. (June 8, 2021), https://d3n8a8pro7vhmx.cloudfront.net/njisj/pages/1427/attachments/original/1578427404/ContinuumCareInfographics_Slide03.pdf?1578427404; Samantha Harvell et al., Promoting a New Direction for Youth Justice: Strategies to Fund a Community-Based Continuum of Care and Opportunity (Mar. 2019), https://www.urban.org/sites/default/files/2019/03/26/new_direction_for_youth_justice_summary.pdf.

[29] The mission statement of the Juvenile Justice Commission, which maintains New Jersey's youth prisons, states in part, that it engages in "providing youthful offenders with a continuum of rehabilitative services and *sanctions, in appropriate settings* that promote positive growth and development opportunities." *JJC Mission Statement*, Dept. of Law & Pub. Safety, Off. Att'y Gen. Juv. Just. Comm'n (June 8, 2021), https://www.nj.gov/oag/jjc/aboutus_mission_statement.html (emphasis added).

[30] N.J. Inst. For Soc. Just., Youth Justice Toolkit: A Community Led Restorative Justice Approach, supra note 16.

[31] Includes hiring a team of 3 full-time master's degree level clinicians and one full time master's level clinician/supervisor. Figure includes office space, computers, supplies, incentives, training fees, etc.

[32] Email from Paul Boxer, Professor of Psychology, Rutgers Univ. to author (May 14, 2021 10:27 EST) (on file with Ashanti Jones).

[33] Email from Sharon Lauchaire, *supra* note 5.

[34] Off. of Mgmt. & Budget, *supra* note 4, at D266 (the cost of youth incarceration includes but is not limited to $39,333,000 for Institutional Control and Supervision and $13,682,000 for Institutional Care and Treatment).

[35] N.J. Inst. For Soc. Just., Youth Justice Toolkit: A Community Led Restorative Justice Approach, *supra* note 16 at 1.

[36] Hannan Adely, *Most NJ Students Have Computer Access, But That Won't Close Divide, Advocates Say*, NorthJersey.com (Nov. 20, 2020), https://www.northjersey.com/story/news/new-jersey/2020/11/20/nj-digital-divide-shrinking-but-challenges-remain-amid-pandemic/6332846002/.

[37] "Opportunity youth" generally refers to young people who are neither enrolled in school nor part of the labor market. *See Who Are Opportunity Youth?*, Aspen Institute Forum for Community Solutions (June 8, 2021), https://aspencommunitysolutions.org/who-are-opportunity-youth/.

[38] *New Jersey Mental Health Cares*, https://www.njmentalhealthcares.org/ (last visited on June 2, 2021).

[39] *Id.*

[40] Shelley Rouillard & J. Bridget Sheehan-Watanabe, Center for Medicare Education, Center for Medicare Education 2 (2002), https://www.orau.gov/cdcynergy/soc2web/Content/activeinformation/resources/SOC_Setting%20_up_a_Hotline.pdf (explaining how to create a telephone hotline).

[41] *New Jersey Mental Health Cares, supra* note 38.

[42] *What is ASAM Continuum?*, ASAM Continuum (June 6, 2021), https://www.asamcontinuum.org/about/.

[43] Norman G. Hoffmann, UNCOPE (June 6, 2021), http://www.evinceassessment.com/UNCOPE_for_web.pdf.

[44] N.J. Inst. For Soc. Just. Youth Justice Toolkit: A Community Led Restorative Justice Approach, *supra* note 16, at 11.