

Final Report of the
Systems Integration Initiative
Mental Health Task Group

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Initiative
Resource Committee

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Mental Health Task Group Participant Roster

Task Group Chair: Susan McLaughlin, King County Mental Health, Chemical Abuse & Dependency Services Division

Name	Agency
Anne Lee	Team Child
Barbara Vannatter	MHCADSD
Ben Kaplan	SCRAP
Bill Barrett	DCFS
Cathy Clem	Parent Coordinator
Debra Robinson	Project ROYAL
Diane Rayburn	Juvenile Probation Counselor
Gene McConnachie	DSHS/DDD
Geri Horrobin	Juvenile Probation Counselor
Harry McCarthy	Superior Court - Judge
Irma Hill	KCDDD
Jan Solomon	Superior Court - BECCA
Jana Heyd	SCRAP
Judy Dubester	Private Attorney
Karen Pillar	Team Child
Kate Naeseth	South King County IST
Kim Noel	PSESD
Kim Thomas	Parent Coordinator
Leah Rader	JRA
Lee Selah	Children's Administration - Region IV
Lisa Christensen	Public Defender
Marcia Navajas	Detention Health Center
Margaret Tumulty	Reclaiming Futures
Mick Moore	PSESD
Nancy Taft	Children's Administration - Region IV
Page Ulrey	Prosecutors' Office - Juvenile Division
Rebecca Kirkland	Juvenile Probation Counselor
Riva Zeff	
Sandy Tomlin	MHCADSD
Sherry Axson	Parent Coordinator
Steve Williams	Parent
Susan McLaughlin	MHCADSD
Theresa Winther	Metro and Eastside IST

Executive Summary

There is a growing body of evidence that suggests a large number of youth in contact with the juvenile justice system have identified mental health and substance use disorders (Skowyra & Coccozza, 2006). In fact, estimates have consistently found up to 70% of youth have a diagnosable disorder and as many as 27% have a serious mental health disorder. Failing to intervene early and effectively to treat these youth can result in tremendous human and financial costs (Burrell, 2006).

Skowyra & Coccozza, in their recent publication *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System* (2006) identify a number of barriers to meeting the mental health and substance abuse needs of these youth including:

- Confusion across service delivery and juvenile justice systems as to who is responsible for providing service to these youth
- Inadequate screening and assessment
- Lack of training, staffing, and programs necessary to deliver mental health service
- Lack of funding and clear funding streams to support services
- A dearth of research available that addresses the nature of mental health and substance use disorders in juvenile justice involved youth and the effectiveness of treatment models.

King County, Washington is no exception to these challenges. A study conducted by the King County Mental Health, Chemical Abuse & Dependency Services Division (MHCADSD) and the then, Department of Youth Services (now separated into King County Superior Court and the Department of Adult and Juvenile Detention) in 1999 showed that every youth in the sample (n = 107) appeared to have at least some level of mental health need and 80% of youth seen in the DYS Mental Health Clinic met eligibility criteria for the publicly funded mental health system. Approximately 88% of these youth presented with co-occurring mental health and substance abuse problems. Despite the large level of need, only 20% of youth were actually enrolled in the public mental health system at the time. This data needs to be further examined and prevalence studies must be completed to better understand why youth and families are not accessing mental health services. Additional barriers identified by parents include the Washington State age of consent that allows youth age 13 and older to refuse mental health and substance abuse treatment.

In May 2005, The King County Systems Integration Initiative chartered a Mental Health Task Group to examine the continuum of mental health services available to children, youth, and families, to identify gaps within the continuum and to make specific recommendations regarding resources, services, and supports needed to develop a comprehensive continuum of care for youth with mental health needs involved in the juvenile justice process.

The Task Group would like to ensure that all programs, policies, etc. that are developed as a result of these recommendations consistently attend to the appropriate gender, ethnicity, race, age, sexual orientation, socio-economic status and faith of the youth and families involved. Furthermore, any attempts to improve screening, assessment, and treatment of youth within the judicial process should be done in full partnership with the

youth and families involved as they have a unique experience and expertise that is critical to successful reform. Finally, any effective planning and development of community-based services will require a more recent and more comprehensive prevalence study of the justice population to identify and more thoroughly understand the needs of these youth.

The specific recommendations of the Mental Health Task Group are as follows:

1. Develop a standardized screening and when necessary follow up assessment, of mental health and chemical dependency concerns for all youth in contact with the juvenile justice system including status offenders and criminal offender youth.
2. Develop a guidebook that details what information can be shared with whom, and under what circumstances, as it pertains to communication between mental health and chemical dependency providers and other child serving systems including juvenile justice, child welfare, and education.
3. Develop court policy controlling the use of mental health and substance abuse screening information to ensure that information collected as part of a pre-adjudicatory screen is not used inappropriately or in a way that jeopardizes the legal interests of youth as defendants.
4. Develop short-term crisis stabilization beds that provide an appropriate level of safety and can serve the most challenging and aggressive youth by providing comprehensive evaluation and stabilization for return to the community.
5. Increase funding mechanisms for ongoing mental health and substance abuse treatment for youth and families not eligible for Medicaid so that they may receive necessary treatment.
6. Increase the capacity to provide a collaborative planning process among the youth, family and service agencies to create a system of care coordination that can be initiated at ANY point in the judicial process and that supports and follows the youth and family throughout and beyond their juvenile justice involvement.
7. Increase capacity and access to research-based treatment programs within the community that can meet the individualized needs of youth and families presenting to the justice system.
8. Increase the capacity and accessibility to Parent Partner positions to include access at the detention center to help families navigate the justice system and to provide ongoing support to the parents/caregivers of these youth.
9. Examine strategies to improve coordination and collaboration between the mental health and substance abuse systems and the juvenile justice systems at all stages of the judicial process. Strengthen partnerships between mental health and other child serving systems including child welfare, King County School Districts and the Office of the Superintendent of Public Instruction (OSPI).

10. Utilize partnerships with education and primary care to develop strategies for prevention and early intervention of mental health and substance abuse problems. Professionals in the juvenile justice and mental health system need to learn about the rights of youth to special education screening, assessment and services at all ages in the public school system and to incorporate advocating for the rights of youth to receive those services as early as possible.
11. Provide regular, ongoing trainings for all justice personnel on mental health issues and the mental health system.
12. Provide Cross System Training that includes information regarding the different child serving systems, community resources and services available and strategies to partner effectively across systems.

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Overview

There is a growing body of evidence that suggests a large number of youth in contact with the juvenile justice system have identified mental health and substance use disorders (Skowyra & Coccozza, 2006). Rates of mental illness are substantially higher in the juvenile justice system than those detected in the general population (Grisso & Barnum, 2000). In fact, estimates have consistently found up to 70% of youth have a diagnosable disorder and as many as 27% have a serious mental health disorder. Additionally, among those youth with at least one mental health diagnosis, approximately 60 percent also met criteria for a co-occurring substance use disorder (Skowyra & Coccozza, 2006). Failure to intervene early and effectively treat these youth with mental health disorders results in tremendous human and financial costs. Untreated, these youth cost juvenile detention center and correctional facilities millions of program dollars in individual supervision and inappropriate programming (Burrell, 2006). Youth who do not receive treatment often end up cycling through the child systems and falling deeper into the criminal justice system.

The President's New Freedom Commission Report on Mental Health (2003) states that Americans with mental illness deserve excellent and care and emphasizes the importance of working across child-serving systems to meet the needs of youth with mental health problems interfacing with the juvenile justice system. However, with the closing of many mental health programs and institutions, juvenile justice agencies have become the "mental health placements of last resort" since the late 1980s (Burrell, 2006). This has resulted in an increasing number of children and youth with mental health problems entering the justice systems for treatment.

Given these findings, it is not surprising that many juvenile justice officials have identified caring for youth with serious mental health problems – and the multiple and complex issues surrounding the treatment of these youth – as among their greatest challenges (Coccozza & Skowyra, 2000). According to Coccozza & Skowyra (2006), efforts to address mental health and substance abuse problems for these youth are challenged by a number of barriers including:

- Confusion across the different child serving systems and the juvenile justice system, at both the policy and practice levels, as to who is responsible for providing service to these youth
- Inadequate screening and assessment for mental health and substance abuse issues
- Lack of training, staffing, and programs necessary to deliver mental health service
- Lack of funding and clear funding streams to support services
- The dearth of research available that addresses the nature of mental disorders in juvenile justice involved youth and the effectiveness of treatment models

King County, Washington is no exception to these challenges. A study conducted by the King County Mental Health, Chemical Abuse & Dependency Services Division (MHCADSD) and the then, Department of Youth Services (now separated into King County Superior Court and the Department of Adult and Juvenile Detention) in 1999 showed that every youth in the sample (n = 107) appeared to have at least some level of mental health need and 80% of youth seen in the DYS Mental Health Clinic met medical

necessity criteria for the publicly funded mental health system. Approximately 88% of these youth presented with co-occurring mental health and substance abuse problems. Despite the large level of need, only 20% of youth were actually enrolled in the public mental health system at the time. The findings from this study are limited in that they only targeted youth referred to the mental health clinic due to acute mental health needs and therefore do not reflect the overall need of the general population. More recent and comprehensive data is needed to fully understand the need and estimate the scope of resources needed to meet that need and to better understand why youth and families are not accessing mental health services. Other barriers that parents have identified include the current Washington State Age of Consent that allows youth aged 13 and older to refuse mental health and substance abuse treatment. Many youth this age are refusing treatment, leaving parents with limited options.

In May 2005, The King County Systems Integration Initiative chartered a Mental Health Task Group to examine the continuum of mental health services available to children, youth, and families, to identify gaps within the continuum and to make specific recommendations regarding resources, services, and supports needed to develop a comprehensive continuum of care for youth with mental health needs involved in the juvenile justice process.

The Task Group would like to ensure that all programs, policies, etc. that are developed as a result of these recommendations consistently attend to the appropriate gender, ethnicity, race, age, sexual orientation, socio-economic status and faith of the youth and families involved. Furthermore, any attempts to improve screening, assessment, and treatment of youth within the judicial process should be done in full partnership with the youth and families involved as they have a unique experience and expertise that is critical to successful reform. Finally, any effective planning and development of community-based services will require a more recent and more comprehensive prevalence study of the justice population to identify and more thoroughly understand the needs of these youth.

The key to connecting youth to treatment is early engagement that is youth friendly and youth focused. Services must be relevant to youth and provided in a model that is accessible and engaging for youth culture. This includes services that travel to where the youth are and attend to the unique youth culture. Families must also be engaged in the treatment of youth. Services must focus treating the whole family, and not just the youth in isolation.

The Mental Health Task Group identified seven areas of consideration that pose barriers or challenges to meeting the mental health and/or substance abuse needs of youth in contact with the justice system including 1) screening and assessment; 2) information sharing; 3) community-based crisis services; 4) community-based treatment; 5) prevention and early intervention; 6) coordination and collaboration; and 7) training. In addition to these seven areas, there are a number of other barriers and challenges that occur as the result of State laws and mandates. These barriers are beyond the scope of the Task Group but the group felt it important to acknowledge that these barriers exist and that any attempts to improve services are done in the context of existing laws and mandates. The specific recommendations of the Mental Health Task Group are as follows:

I. Standardized Screening and Assessment for youth involved in the justice system

The most critical first step to improving access and treatment of mental health and chemical dependency disorders for youth in the juvenile justice system is through systematic screening and assessment. It is important to have a reliable and valid way in which to effectively identify and respond to the needs of these youth. Treatment outcomes and placement decisions can be significantly enhanced when decision-makers have access to comprehensive information about a youth's mental health and substance abuse needs (Trupin & Boesky, 1999).

Despite estimates that a large number of youth have mental health and chemical dependency concerns, currently the King County juvenile justice system (including their contracted community service providers) does not have a consistent system to screen and provide assessment based upon a reliable screen. In fact, many youth who enter the juvenile justice system do not receive any kind of mental health or substance abuse screening (i.e., At Risk Youth, Truant Youth). Other screenings happen either inconsistently or for only a small number of youth involved in the judicial process.

The following screenings and assessments are currently being administered in King County:

Detention:

- MAYSI 2 - administered to all youth admitted to detention, flags youth through validated scores for an in-house mental health "Crisis Assessment" and intervention. High scores for substance abuse prioritizes referrals for GAIN assessments while a youth is in detention.
- Crisis Assessment does not have a specific format and is based on a face to face -interview with mental health providers.

Intake Probation

- All pre-adjudicated youth consistently receive the Washington State Risk Assessment Tool (WSRAT) Pre-Screen which places youth on a level of supervision (assessing low, moderate high risk to re-offend)
- CRAFFT - all pre-adjudicated youth are inconsistently screened for substance abuse only. This was set up to trigger an immediate referral for assessment (in the community or in detention) but due to limited capacity this has not been the case
- Global Appraisal for Individual Needs (GAIN) -currently the substance abuse and mental health assessment utilized on all youth referred for assessment in publicly funded KC youth serving agencies. Youth are referred for assessment by attorney or probation counselor.

Low Level Supervision (assigned a student who refers youth to community services but does not provide formal probation supervision)

- All pre-adjudicated youth consistently receive the Washington State Risk Assessment Tool (WSRAT) Pre-Screen
- May be referred to an agency for screening/assessment by a student.

Moderate and High Risk Community Supervision (assigned a probation counselor once adjudicated)

- A Washington State Risk Assessment Tool (WSRAT) long assessment is administered on all moderate and high risk youth within 30 days of receiving the case. The youth and probation counselor identify 2-3 areas that they will work on while on supervision.
- CRAFFT -may complete if they want to refer for assessment -not currently systematic.
- Global Appraisal for Individual Needs (GAIN) -currently the substance abuse and mental health assessment utilized on all youth referred for assessment in publicly funded KC youth serving agencies. Youth are referred for assessment by attorney or probation counselor.

Diversion

- Referred out to KC Department of Community and Human Services' contracted community based providers, most likely receiving the GAIN.

Children in Need of Services:

- A Washington State Risk Assessment Tool (WSRAT) Pre-Screen is administered occasionally (primarily to be eligible for FFT or ART programs)
- FRS Assessment is included as part of the petition process.

Truancy

- A Washington State Risk Assessment Tool (WSRAT) Pre-Screen is administered occasionally (primarily to be eligible for FFT or ART programs) not done as much for truancy as for ARY, as schools are the more direct responders (usually).

At-Risk Youth

- A Washington State Risk Assessment Tool (WSRAT) Pre-Screen is administered occasionally (primarily to be eligible for FFT or ART programs)
- FRS Assessment included as part of the petition process.

It is clear that not all youth are consistently screened and/or assessed for mental health or chemical dependency issues when entering the King County juvenile justice system. More consistent and reliable screening would assist in the appropriate identification of youth in need of treatment and would help staff identify appropriate programs to refer youth to.

Efforts to develop a standardized mental health and substance abuse screening have already begun. Washington State has adopted the GAIN Short Screener (GSS) as the standardized behavioral health screen (for Mental Health and Drug/Alcohol) to be used as of Jan 2007. There have been recent efforts to integrate the WASRAT Pre-screen and the GSS across the state. This would integrate, standardize and institutionalize a behavioral health and risk screen within a specific time-frame. In early October, the WASRAT Quality Assurance Committee met to discuss this possibility with Robert Barnowski (WSIPP); and the decision was to move forward to

analyze the details of this integration (with WSIPP and Chestnut Health's Dr. Michael Dennis).

Recommendations:

- Develop a proposal to access technical assistance and funding from the MacArthur Foundation to hire consultants (Robert Barnowski, Michael Dennis, and Thomas Grisso) to identify and/or develop a standardized screen for mental health and substance abuse issues that can be integrated in the WASRAT.
- Once an appropriate screening tool is identified, all youth who come in contact with the justice system (both for offender and non-offender, or BECCA youth, should be systematically screened for mental health and substance abuse needs both to identify conditions in need of immediate response, such as suicide risk, and to identify those youth who require further mental health assessment or evaluation.
 - Screening and assessment should occur at the youth's earliest point of contact with the system, such as at probation or juvenile court intake, as well as at all key transition points, and should be used to inform decision-making around diversion or other next steps (Skowryra & Coccozza, 2006).
 - The mental health and substance abuse screen should be combined with the risk assessment to help guide decisions about the youth's suitability and need for diversion to community-based services and programs.
 - All screening and assessment tools and processes developed should be culturally competent and adapted to meet the needs of youth or color and other minority populations (i.e., girls, sexual minority youth)
- Youth who screen positive for mental health or substance abuse needs should have timely access to further assessment

II. Information Sharing

The ability to share the appropriate information regarding a youth's mental health and substance abuse needs in a timely and accurate manner among providers and juvenile justice professionals is critical to effective identification and intervention at the earliest point within the judicial process. However, there are a number of Federal and State laws that regulate confidentiality and information sharing for the mental health and substance abuse systems, at times creating barriers to timely information sharing.

These laws need to be thoroughly researched to determine the benefits and potential detriments to children by either increasing or restricting the information sharing that occurs in the juvenile justice system about their health needs, especially mental health and chemical dependency issues. Service providers and justice personnel need a more comprehensive understanding of what information can be shared, with whom, and under what specific circumstances. Additionally, the timely transfer of information from one stage to another during the judicial process (i.e., from intake to detention or from detention to community supervision) must be examined and policies and procedures identified to ensure that critical information regarding a youth's mental health or substance abuse status is passed forward. This ensures not

only that the youth not have to endure repeated screenings and assessments, but also that the youth receive the services and supports necessary to meet his/her needs as quickly as possible.

In addition to the barrier of *what* information can be shared among service providers and juvenile justice staff, there is also concern about how this information will be used in the judicial process. While youth who come into the system could potentially receive a variety of screenings that may reveal either past, present or emerging mental health and chemical dependency needs, it is unclear how the information in those screenings can and should be shared. If used inappropriately, screenings do not always guarantee services at the end of system involvement. For example, the more impaired a youth is at the initial screening, the less likely that youth will be to be released from detention.

Information sharing can help systems be more efficient. However, it can also lead to inadvertent disclosing of confidential information that harms a child or their family. The goals of different individuals in the juvenile justice system as well as other child serving systems are different and sometimes in conflict with other professionals or the youth and family's goals. Furthermore, there are sometimes unintended consequences of sharing information. (For example, a probation officer mentioning to a school counselor that a youth is undergoing an SAY evaluation can lead to the youth being expelled from school). One of the core underlying principles that guide the Blueprint model is that information collected as part of a pre-adjudicatory mental health screen should not be used in any way that might jeopardize the legal interests of youth as defendants (Skowyra & Coccozza, 2006).

Policies controlling the use of screening information will be necessary to ensure that information collected as part of pre-adjudicatory mental health screening is not used inappropriately or in a way that jeopardizes the legal interests of youth as defendants. For example, the policy could restrict the use of pre-trial mental health screening information to the use for which it was intended – to identify any immediate mental health concerns and the need for further assessment. A few states are beginning to develop court policies to specifically address this issue and the National Center for Juvenile Justice and Mental Health could be a potential resource to assist in the development of such policies. Similar policies also exist within the King County Drug Courts and could be used as guides in this process.

Recommendations:

- Put together a team that can study the impact of information sharing on youth and their juvenile justice outcomes – from the perspective of all sides – youth, probation, prosecutor, judge, detention, mental health system and community. The work group should be responsible for analyzing the confidentiality and HIPAA laws and developing a guidebook for juvenile justice and mental health providers that inform them what information can be shared, with whom, and under what circumstances.
- Develop policy within the justice system that controls the use of mental health and substance abuse information collected pre-adjudication so that it is not used inappropriately or in a way that jeopardizes the legal interests of the youth. The

- National Center for Juvenile Justice and Mental Health could potentially provide technical assistance in the development of such policies.
- Provide all professionals with training not just on what the laws say about information sharing, but about the impact of information sharing on the system and the youth and family. Professionals should have a working understanding of the best ways to share information, the purpose of sharing information and the consequences of sharing information. What is responsible and effective information sharing? (See the Robert Wood Johnson Foundation Handbook).

III. Community-based Crisis Interventions

Frequently, a youth's disruptive or inappropriate behavior that lands them in the justice system is the result of symptoms associated with an underlying mental health or substance abuse disorder. For example, a youth with Bipolar Disorder who is currently manic may become aggressive and assaultive at home. The family is in a crisis and the youth is presenting as a danger to others in the home. The police may be called to assist in intervening with the youth. If the appropriate mental health crisis services are not engaged and/or the appropriate service is not available to the youth, he/she might be arrested for an assault and held in detention. While detention is typically viewed as an inappropriate placement to stabilize a youth in crisis, it ends up being the default spot when hospitals don't have enough beds for youth or when a youth does not meet medical necessity criteria to access an inpatient hospital bed.

Washington State is experiencing a critical shortage of inpatient hospital bed capacity for youth, leaving many youth who are in crisis and who are willing to voluntarily be placed in a hospital without a place to go. Furthermore, many community hospitals refuse to admit the most challenging youth due to the level of severity of need and/or aggressive and dangerous behaviors the youth may be exhibiting, including youth who are committed under the Involuntary Treatment Act (ITA). King County MHCADSD was recently awarded funding from the State to develop a local Evaluation and Treatment Center for Adolescents (E&T) in partnership with the North Sound Regional Support Network. This secure, short-term facility would allow youth in a mental health crisis to be temporarily held for evaluation and stabilization and potential return to the community. The planning for such a facility is in the early stages but an adolescent E&T would be a critical addition to the King County crisis continuum and help alleviate problems associated with the shortage of inpatient beds.

However, not all youth in a mental health crisis are in need of such a high level of intervention as inpatient hospitalization provides. Currently in King County there is a Children's Crisis Outreach Response System (CCORS) that provides urgent outreach and crisis stabilization to youth and families in crisis. The CCORS team provides crisis stabilization through community-based therapeutic homes but there are no hospital diversion beds available or other type of step up/step down option that provides an option between community-based treatment and inpatient hospitalization. Adding this level of resource to King County would fill a critical gap in the crisis continuum of care and help reduce the number of youth with mental illness entering the justice system.

Recommendations:

- Develop additional crisis stabilization beds that provide an appropriate level of safety and can serve the most challenging and aggressive youth. Ensure a sufficient number of beds available based on need, county size, and geographic location. These crisis stabilization beds should provide
 - quick access to psychiatric services
 - qualified masters level mental health professionals who can work with the youth on stabilizing acute symptoms due to mental health issues
 - Staff trained in the techniques that are effective to engage parents and youth in treatment so that the youth especially can see the value of services and treatment and so that parents will accept the youth back into their homes as well as all the services and changes that the parents have to make to their homes to care for a mentally ill youth.
 - appropriate discharge planning such as linkage back to community based mental health, educational, and medical services.
 - In addition, these facilities will provide medical oversight so that they can act as a step down/up from hospital diversion, and could act as a linkage to CLIP if a youth is unlikely to be appropriate to return to community based outpatient services.
 - Access to these beds should be linked to the current mental health crisis continuum (i.e., CCORS and CCS services) to ensure smooth, seamless transitions and coordinated use of resources.
 - Youth in a crisis stabilization bed should have access to a community care facilitator to coordinate all systems over time and provide intensive wraparound to the youth and his/her family.

IV. Non-crisis interventions and treatment programs

The 2000 Surgeon General's Report on Children's Mental Health indicated that approximately 20 percent of children and youth in the general population experience a diagnosable mental health disorder, with 10 percent of youth experiencing illness severe enough to cause impairment (USDHHS, 2000). However, the report estimated that as few as 10 percent of those youth in the general population with severe mental illness receive the treatment that they need (USDHHS, 2000). There is simply not enough mental health treatment funding and capacity to respond to the need. The situation for youth in the justice system is no exception.

One of the most significant barriers to accessing appropriate mental health and substance abuse treatment for juvenile justice involved youth in King County is funding. It is estimated that approximately 50% of youth in the King County justice system are not eligible for Medicaid and therefore are not eligible for services through the publicly funded mental health system. If a family is not eligible for the Medicaid funded services they must rely on private insurance benefits, if available, or they must pay for services themselves. When private insurance benefits are available, they are generally very limited and do not provide coverage for the full range of services to meet the complex needs of the families engaged in the justice system. However, in most cases there is no insurance benefit and many of these families do not have the resources to pay for the ongoing expenses associated with mental health or substance abuse

treatment. Many of these youth go untreated and eventually find themselves in contact with the justice system. If the need for treatment cannot be addressed because the family's insurance coverage is exhausted or other resources or unavailable, another plan must be developed.

A second barrier to effective community-based treatment for youthful offenders is the lack of coordination of services and linkage to community-based services and supports. Many youth and their families entering or returning to the juvenile justice system need support navigating the system and identifying where to go to get the help they need. When youth and families are not hooked up to services in any coordinated way, there is no assurance that the youth or family will follow through on engaging in services. King County currently has a number of active programs that provide care coordination, wraparound, and family support to youth involved in the justice system. These programs include 7 FTEs for CD Advocacy Wraparound for offenders with mental health and/or substance abuse problems serving approximately 182 youth and their families per year; 1 FTE for Project TEAM Wraparound for offenders with mental health disorders that serves approximately 26 youth per year; 1.5 Project TEAM Wraparound care for ARY/CHINS youth serving approximately 30 youth per year; 3 FTEs for Interagency Staffing Team Wraparound coordination for multi-system involved youth with serious emotional disturbances serving approximately 120 youth per year; and 4 family support networks/organizations that provide peer counseling and/or parent/youth partners as needed to parents and caregivers of youth with serious emotional disturbances some of which may be involved in the justice system.

Despite the availability of these wraparound/care coordination programs, there are a number of limitations to the existing services. First of all, many of the programs require that a youth commit an offense prior to being eligible for service. In addition, with so many programs available to youth (i.e., MST, FFT, etc.) it is difficult for JPCs to know exactly where to refer a youth and his/her family and no clear and consistent criteria to make that determination. Finally, some programs and supports, such as the IST and the Parent Networks of support lack current capacity to meet the community demand.

A core fundamental principle of the Blueprint model is that youth should not have to enter the juvenile justice system solely in order to access mental health services or because of their mental illness. In order to do this, community based treatment programs must be available and accessible to all at-risk youth with mental health and substance abuse needs. King County is fortunate to have developed a number of Evidence-based programs available to youth within the justice system such as Multi-Systemic Therapy, Functional Family Therapy, and Aggression Replacement Therapy. However, each of these programs provides time-limited intervention that target specific behaviors. In order to ensure a complete continuum of community-based services, there needs to be a system of care that can provide before and aftercare to youth and families while receiving "doses" of structured programs. Additionally, the EBPs that do exist in King County are limited and do not address all of the mental health problems that a youth might present with (i.e., PTSD, FAS/FAE, para-suicide and suicidal behavior, etc.) There is a need to identify other best practices to meet the

complex needs of these youth and developed specialized programs to target specific, challenging populations.

Finally, there are currently no comprehensive in-home services like Family Preservation Services (FPS) that are provided by the Regional Support Network. While some in home services do exist in the mental health system they are not as comprehensive as the FPS model. Furthermore, there are potential challenges with engaging families and youth in treatment due to the significant stresses or problems that interfere with meeting basic needs, interacting with the community successfully, and the capacity to parent effectively. These barriers create a revolving door effect with youth cycling in and out of systems and detention because they have not effectively participated or engaged in treatment. The community needs to develop mechanism for outreach and engagement of families and youth. In the 1999 Profile study of King County youth, at least 41% of the unenrolled youth were not interested in being referred for mental health services at the time of the study.

Recommendations:

- Increase funding for ongoing mental health and substance abuse treatment for families not eligible for Medicaid so that they may receive necessary treatment.
- Create system of care coordination that can be initiated at **ANY** point in the judicial process and supports and follows youth and family throughout juvenile justice involvement. Increase the capacity to provide a collaborative planning process, i.e. wraparound, among the youth, family and service agencies. Families are linked to Care Coordinators and parent partners who can help engage youth and families, provide intensive case management and linkage to services, help them establish supportive teams to create care plans that are strengths based and needs driven, and/or build a network of community supports.
- Create policy that allows (and requires) juvenile probation counselors, social workers, and other key system partners to participate in team meetings and collaborative planning for youth in families.
- Develop enhanced community-based interventions to serve the justice population that are:
 - Highly structured, intensive, and focused on changing specific behaviors
 - Emphasize the development of basic social skills
 - Provide individual counseling that directly addresses behavior, attitudes, and perceptions
 - Sensitive to the youth's race, culture, gender, and sexual orientation
 - Use community-based treatment rather than institutional-based programs
 - Involve family members as partners in the treatment of their children
 - Provide individualized services, support and supervision to each child and family
 - Include an aftercare component
 - Use trained mental health professionals
 - Are research based
- Create a Family Preservation Service model within the system of care that includes parent coaching, solution-focused family therapy in the home, 24-hour crisis stabilization, and family support.

- Create a community connector position at the detention center to bridge the link to services and supports. The role of this person could be to assist in identifying the appropriate community-based intervention based on the outcome of the mental health and substance abuse screening/assessment plus the consideration of the risk assessment. This diversion and post-detention mechanism should be available at all key decision-making points with the judicial processes.
- Create a Parent Partner position at the detention center to help families navigate the justice system and provide ongoing support to the parents/caregivers of these youth. Navigate the juvenile justice systems as well as better understand their rights and responsibilities.

V. Improved Coordination and Collaboration between the Juvenile Justice and Mental Health Systems

Cross system collaboration is a cornerstone to better meeting the mental health and substance abuse needs of youth in the justice system (Skowyra & Coccozza, 2006). The needs and issues surrounding individuals with mental health disorders cannot be placed at the doorstep of any single agency or system – no one system can do it alone. An effective solution requires that multiple agencies coordinate and integrate strategies and services.

In 1998, King County Mental Health, Chemical Abuse & Dependency Services Division (MHCADSD) was the recipient of the Comprehensive Community Mental Health Services for Children and their Families Initiative grant, also known as the Systems of Care model. The grant helped to encourage the development of multi-agency partnerships involving mental health, juvenile justice, child welfare, and education to provide services using a strengths-based approach that is driven by the individual needs of the youth and family.

The work of the King County Systems Integration has taken this coordination and collaboration one step further. Led by an executive committee of judges, court administration, child welfare administration, private foundations, education and social services administration, the King County Systems Integration Initiative has sought to provide better, more effective and efficient services to youth who cross multiple systems. This initiative provides the infrastructure to continue efforts to improve collaboration and coordination among the different child serving systems by bringing professionals together, developing protocols and policies, and ensuring that the multiple needs of youth are being met.

Improving the coordination and collaboration between mental health and substance abuse professionals and the justice personnel will ensure that youth with mental health and substance abuse needs will be identified early on and can be appropriately linked to community-based services at the earliest point possible within the judicial process. All steps of the process must be examined in more detail to identify ways that this collaboration can be improved. As a first step, improving coordination and collaboration will help to maximize all of the current resources that are available and or mandated by law and help ensure families, youth, and other professionals have access to those resources.

Recommendations:

- Review the critical intervention points within the judicial process to identify where there are opportunities for improved collaboration, identification, diversion, and treatment for youth with mental health needs. The intervention points include 1) initial contact with law enforcement; 2) intake; 3) detention; 4) judicial processing; 5) disposition, and; 6) re-entry.
- Coordinate monthly meetings with court staff and service providers (anonymous case staffing) to encourage a team approach to assessment and case management
- Whenever possible, include family members and caregivers in the collaborative process as families are critical stakeholders who should be involved in all planning for their child. In particular, identify ways to connect with the family and/or a youth's therapist within 24 hours of detainment.
- Improve coordination and collaboration among police and the CCORS program so that when there is question as to a youth's mental health status, a team of children's mental health specialists can provide outreach and urgent assistance to the family with the potential to divert from the justice system.
- Provide training and education to all staff so that they have a thorough understanding of the community-based services and programs available to which a youth can be referred.
- Develop funding for community service providers to outreach and link with youth while in detention so that continuity of care is provided and to enhance the ability to refer detained youth in need of community mental health services to community providers post detention.

VI. Prevention and Early Intervention

A major deterrent of potential youth who enter the juvenile justice system is the ability to provide prevention and early intervention services that assist in the stability of good mental health with the accompanying prevention/reduction of negative behaviors. On average, one student in every classroom is expected to have serious emotional disturbance (President's New Freedom Commission on Mental Health, 2003). One key opportunity to prevent mental health issues that contribute to delinquency is the ability to utilize the schools as a resource to identify young students in need of mental health support and provide or connect them to the needed services. Mental health screening, referral and service in schools decreases stigma, and increases access, thereby removing barriers to service. (Surgeon General's Report, 2000)

School and community partnerships have the potential of significantly offsetting the current landscape of mental health needs of King County children. Early identification and intervention can lead to prevention of some childhood mental illness and the prevention of long-term damage of others. Prevention services focus on a strength based and systems oriented approach designed to meet needs of individuals and groups before concerns manifest. The focus therefore is on creating supportive environments, increasing social emotional skills, and tending to children and families who exhibit concerning behaviors at lower levels of intensity, and at younger ages. Early recognition and support requires a coordinated,

systemic response to behaviors of concern manifested by children and their families. Three such early response models sometimes found in schools include: (1) Wrap Around, (2) Student Assistance Programs, and (3) the UCLA Mental Health in Schools program. For these models to be effective, prevention and early intervention must be sensitive to the following components:

- *Communication/Coordination Between Schools and Agencies:* Schools generally lack the necessary infrastructure to provide mental health supports around all students. Referral, screening/assessment, and communication protocol are not consistently utilized between mental health agencies and public schools. Policies and practices differ greatly between schools and providers in relation to confidentiality, training, and identification, referral, and case-management practices. In addition, while school psychologists do use standardized assessment screening tools specific to special education referrals, there are a number of assessment tools utilized by King County youth service agencies but not by schools. Examples include:
 - A locally developed full bio/psycho/social assessment tool (16 pages in length)
 - Global Appraisal for Individual Needs (GAIN)
 - GAIN Q (Quick Screener) Screener for Co-occurring disorders
 - Child Adolescent Functional Assessment Scale (CAFAS)
 - Child Adolescent Needs Assessment Scale (CANS)
 - Substance Abuse Subtle Screening Inventory (SASSI)

There must be cohesion between screening/assessment, referral procedures, staff development, policies and practices to insure the proper continuum of services.

- *Recognition of co-occurring disorders and training specific to substance abuse:* According to the Dept of Health and Human Services (2002) there is a significant correlation between youth with behavioral and affective disorders and youth engaged in substance abuse. Currently, there are long term but under-funded relationships between local outpatient treatment agencies and secondary public schools. Training in dual disorders is limited but constructs are in place for early identification, prevention, and increased access to services and support.
- *Reduction of cultural and social barriers that result in disproportionate service delivery:* Students of color and/or students living in poverty are disproportionately underserved in the mental health system as a result of cultural barriers, reduced access to services and lack of health insurance.

The science of prevention has been well developed over the past three decades to inform mental health, substance abuse, community collaborations, and education fields on effective strategies for promoting health and decreasing delinquency. Prevention Centers in every Washington State Educational Service Districts are resources to schools and their community partners to create the necessary infrastructure for supportive student assistance programs. By focusing on coordinated prevention and intervention services, foundational goals of schools, community, and family are supported for children and youth.

Recommendations:

- Develop model policy/protocol designed to strengthen partnership and collaboration between education systems (School Districts, ESD, OSPI), juvenile justice, mental health services, and ethnic specific community organizations;
- Utilize a student assistance and/or community-based wrap-around model that includes culturally competent Family Support Specialists or Mental Health Liaisons for every school to provide screening/assessment, training to parents and teachers, identification of family needs, and linkage to support services to increase access. In so doing, this service will provide early recognition of at-risk youth before juvenile justice system entry.
- Increase the capacity of Interagency Staffing Teams (ISTs) so that wraparound/care coordination is available to high-risk youth and families across all youth service systems;
- Provide cross training between youth serving systems regarding access and resources. Include emphasis on culturally competent training to teachers and student assistance teams on early recognition and support;
- Develop after school and recreation programs that specialize in children, youth and families with mental health issues;
- Continue to grow the Parent Involvement/Parent Partnership so that trained parents from all cultural backgrounds are available to assist parents and youth in navigating complicated systems;
- Reduce the student-counselor ratio and enable school counselors, psychologists, social workers and nurses to enhance their role as implementers of mental health prevention and intervention programs;
- Work with Public Health and Primary Care systems to identify a school-based service delivery system proactive identification process for mental health disorders. Screen children for emotional or behavioral disorders early in the school years, similar to screenings for visual acuity or other health problems.

VII. Training in Mental Health and the Mental Health Systems

Identifying children within the juvenile justice system with mental health and substance abuse disorders is very difficult because of a lack of training for judicial officers, court staff, detention staff, juvenile probation counselors, and police. There has been very little organized education for any of these critical personnel concerning mental health and substance abuse issues and the mental health system. For example, for judicial officers, training consists of minimal information at judicial college, judicial conferences and an annual retreat.

There are approximately 80 Juvenile Probation Counselors (JPCs) for King County Superior Court, Juvenile Probation. The estimate of JPC's coming to probation with prior experience working with juveniles in a mental health related field is 25% to 30%. Many of the 80 JPC's have no educational background in social work, counseling, psychology or a related field. Current training for juvenile probation counselors and corrections officers entering the juvenile justice field consists of one day devoted to mental health issues at the Training Academy. The training focuses on identifying "behaviors of concern" that may indicate mental health issues, providing staff with the tools to document the necessary information for mental health professionals, as well as some strategies for

managing behavior in the institution. However, there is no training on normal adolescent development or recent brain studies which shed new light on adolescent behavior and currently there is no requirement for JPC's to have continuing education in mental health.

Finally, local police, as first responders in engaging potential youthful offenders, have a primary role in diverting youth from the juvenile justice system when mental health and substance abuse problems are prominent. The Seattle Police Department (SPD) has a basic procedure, called "standing orders" that Officers are required to comply with when dealing with any citizen who exhibits possible mentally ill behavior. These procedures are revised and up-dated on a regular basis. The specific unit that is responsible for the *Mental Health Care Procedure* is the Crisis Intervention Team (CIT), currently supervised by Sgt. Liz Eddy. SPD also has annual training days for all Officers concerning insights and procedures dealing with the mentally ill population. Police officers need more specific training in responding to youth with mental health and substance abuse disorders and who to partner with existing crisis services to de-escalate, stabilize, and divert these youth from the justice system.

Recommendations:

- Require frequent and ongoing training for judges/commissioners, Juvenile Probation Counselors, Detention staff, and police officers on normal adolescent development, as well as recognizing and understanding mental health and substance abuse problems in youth
 - Offer continuing education for all trainings whenever possible.
 - Require a minimum number of training hours/CE credits in issues related to mental health related issues in the juvenile justice system.
 - Training should ensure that justice personnel are informed about the various programs/services and resources offered within our own court and within the community and how to access those services.
 - Training should also include helping juvenile justice personnel better understand the family perspective and to identify ways to take advantage of parental expertise.
- Devote more time at the Juvenile Justice Training Academy to training on mental health and substance abuse issues. Ensure that the Academy Training is conducted by individuals who are experts in child and adolescent mental health and substance abuse.
- Establish a working relationship with a community-based adolescent psychiatrist, psychologist and/or psychiatric nurse to act as a consultant for JPC's and other youth workers within the justice system.

VIII. Legislative/State Issues for further consideration

There were a number of other areas of concern that were discussed during the task group meetings that have a significant impact on youth entering the juvenile justice system but that require legislative action at the state and are beyond the scope of this group. However, we thought it was important to acknowledge these issues and the potential barriers they may create to appropriate treatment. These issues include:

- The Age of Consent

- The Involuntary Treatment Act (ITA)
- The Access to Care Standards
- Work Force Development

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