PENNSYLVANIA PROGRESS
A Juvenile Justice Research, Policy and Practice Series

Addressing the Behavioral Health Needs of Court-Involved Youth

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Pennsylvania is engaged in an ambitious effort to build a "comprehensive model system" for identifying, appropriately diverting, and effectively serving and treating court-involved youth with behavioral health disorders.

Focusing more attention and resources on juvenile justice-involved youth with substance abuse and/or mental health disorders—collectively known as behavioral health disorders—has long been a goal of Pennsylvania's juvenile justice leadership. The Juvenile Justice and Delinquency Prevention Committee (JJDPC) of the Pennsylvania Commission on Crime and Delinquency (PCCD), in its 2003 plan to the Governor, called for the development of uniform standards for behavioral health screening, assessment and evaluation of youth in Pennsylvania's juvenile justice system. Since then, the JJDPC's updated plans have identified the coordination of mental health services for youth in the juvenile justice system as targeted priority issues.

Pennsylvania leaders have agreed on the building blocks of a "comprehensive model system" for addressing the needs of youth with behavioral health disorders in the juvenile justice system.

Now a high-level commitment to coordinated action has come in the form of a "Mental Health/Juvenile Justice Joint Policy Statement." The Joint Policy Statement was drafted by the Mental Health/Juvenile Justice Workgroup (MH/JJ Workgroup), a state-level committee composed of representatives of the juvenile justice, mental health, child welfare, drug and alcohol and education systems as well as families, formed as part of the MacArthur Foundation-supported Models for Change initiative in Pennsylvania. The Statement was endorsed in September 2006 by the leaders of the Departments of Public Welfare and Education, the Juvenile Court Judges' Commission, the Pennsylvania Commission on Crime and Delinquency, the Pennsylvania Council of Chief Probation Officers, the Mental Health/Mental Retardation Program Administrators Association, and the Mental Health Association of Pennsylvania. It lists and describes the basic building blocks of a comprehensive model system—including routine screening and assessment of youth for behavioral health problems, an appropriate continuum of programs and services for diverting and treating them, opportunities for family involvement in their treatment, appropriate protections for their privacy and other legal interests, and sustainable funding mechanisms that support all of these practices—and sets a goal of having all of them in place in all counties by the target year 2010 (see sidebar). This issue of *Pennsylvania Progress* will describe all of these identified building blocks and the ongoing state and county efforts to cement them into day-to-day practice.

MODELS FOR CHANGE IN PENNSYLVANIA

Models for Change is a multi-state effort to create successful and replicable models of juvenile justice system reform through targeted investments in key states. With funding and support from the John D. and Catherine T. MacArthur Foundation, Models for Change in Pennsylvania is focused on bringing about system-level change that (1) addresses the disproportionate involvement of minorities with the juvenile justice system, (2) reforms the way aftercare services and supports are delivered, and (3) improves and coordinates access to behavioral health services for youth in the Commonwealth's juvenile justice system.

Since 2004, Models for Change has supported the state-level policy work of the MH/JJ Workgroup as well as local coordination initiatives in three pilot counties—Allegheny, Chester and Erie. Efforts in all three of the local sites have been aimed at developing multi-system collaborative structures, and each site employs a mental health coordinator to manage and implement the changes decided on by the county's collaborative team. While they all aim at early identification of youth with behavioral health issues, appropriate diversion when possible, and evidence-based treatment in the community, each of the sites has taken its own approach, and has solid achievements to show for it:

- **Early Identification**. Erie County has developed a triage team consisting of mental health clinicians, juvenile probation supervisors and staff, which receives referrals from detention, shelter, treatment court and probation. Between September 2005 and March 2008, about 433 youth's cases were reviewed. Initial screening, assessment and treatment are coordinated through triage.
- **Diversion**. In 2004, approximately 40% of youth who had contact with Allegheny County Juvenile Probation had current or past association with the mental health system. With an eye toward diverting youth with mental health problems, Allegheny County Adult Forensic Unit rolled out a plan to implement a Crisis Intervention Team (CIT) within the City of Pittsburgh Police Department. Seventy police officers volunteered to be specially trained to respond to mental health emergency calls. The purpose of CIT is to divert non-violent individuals with mental illness and co-occurring disorders to community-based treatment and support, thus avoiding arrest, adjudication and placement.
- **Family Involvement**. In an effort to increase family involvement at all levels of planning and implementation, Chester County has hired two advocates from the Parents Involved Network (PIN), a project of the Mental Health Association of Southeastern Pennsylvania. Their roles are to participate in system planning and implementation and to help families with children involved in multiple child-serving systems to work with the different systems and learn how to advocate for themselves and their children. Also, in late 2006, Chester County developed a multidisciplinary team to implement Family Group Decision Making (FGDM) conferences in the county. A FGDM coordinator was hired by Chester County Department of Children, Youth & Families in January 2007, and a number of county and service provider staff have been trained as FGDM conference facilitators. The county's goal is to conduct 30 FGDM conferences per year.

A core team of state and local practitioners active in Models for Change in Pennsylvania is also participating in the Models for Change-supported Mental Health/Juvenile Justice Action Network, which seeks to establish a leadership community committed to finding and implementing innovative ways to identify and treat youth with mental health needs in the juvenile justice system. Pennsylvania's Action Network team will be working with law enforcement partners to increase up-front diversion of youth with behavioral health issues through training that uses the Crisis Intervention Team model.

For further information, documents and resources related to Models for Change and the Mental Health/Juvenile Justice Action Network, see http://www.modelsforchange.net/

A Daunting Task

Coming up with a comprehensive approach to addressing the behavioral health needs of court-involved youth is a daunting task, for several reasons.

First, the size of the group targeted—the exact number of youth in Pennsylvania's juvenile justice system who have behavioral health problems—is unknown. There is no systematic way of identifying these youth, and no statewide collection of data on them. Most estimates of their needs are based on the relatively small proportion of youth in detention and placement facilities.[1] Among youth referred to court generally, or those disposed to some form of court supervision, the proportion with behavioral health problems remains a mystery.

There is clearly an unmet need for community-based behavioral health services among court-involved youth, however. The lack of adequate services for these youth has long been a source of frustration to judges, families, child advocates and juvenile justice system policy makers and practitioners. Problems with public funding of community mental health systems for children and youth and gaps in service delivery have been

well documented in Pennsylvania and nationwide.[2] Too often, as a result of these gaps, juvenile correctional facilities have become mental health treatment facilities of last resort.[3]

And yet there is also a danger of distorting and exaggerating the aggregate treatment needs of this population. As Thomas Grisso, psychiatrist and director of the Law and Psychiatry Program at the University of Massachusetts Medical School, points out, not every troubled youth who may meet criteria for a psychiatric disorder is seriously in need of psychiatric treatment.[4] Some disorders may be acute but temporary. Others are so common that basing resource allocation decisions on their prevalence in the juvenile justice population would be unwise and impractical.

Moreover, the response of Pennsylvania's juvenile justice system to youth with mental health and substance abuse issues must be framed within the system's primary mission—which is to protect the community, hold offenders accountable, and address those competency development issues directly related to the youth's offending behavior. While substance abuse has been firmly linked by researchers with delinquent behavior, the association between mental illness and delinquency is not so clearly established.[5] That means that addressing mental disorders may not always serve the system's primary goal of reducing delinquent behavior. Yet "medical necessity" determinations made on the basis of behavioral health assessments are the driving force behind capturing medical assistance funding for services for delinquent youth.

Early Identification

Since it began meeting in 2004, the MH/JJ Workgroup has directed its efforts toward grappling with all these issues to develop a coordinated mental health/juvenile justice response to youth who are in need of behavioral health treatment—one that (1) allows for early identification, (2) prevents unnecessary system penetration, and 3) provides for timely access to appropriate treatment within the least restrictive setting that is consistent with public safety needs.

The first point, early identification, calls for screening and assessment. Screening youth at the earliest point of contact with the juvenile justice system—ideally at intake—allows for "triaging" of the youth's behavioral health needs. Behavioral health screening is a brief process, usually using a short instrument, to identify youth who have mental health/substance abuse "red flags" that need immediate response (e.g. suicidal ideation), or that require a follow-up clinical assessment or evaluation. Behavioral health assessment, on the other hand, is done by a mental health professional, and is a more thorough, clinical examination of a youth's behavioral health needs. An assessment entails more in-depth collection of information—through psychological testing, clinical interviewing, and review of past treatment interventions.[6]

While there is not a standardized, mandated statewide process for mental health screening and assessment of youth involved in the juvenile justice system, many counties are making progress. In late 2004, the Research Committee of the Pennsylvania Council of Chief Juvenile Probation Officers surveyed all 67 juvenile probation departments on their use of screening and assessment instruments for delinquents. About half indicated that they used some type of tool, though some were risk/needs assessments, not mental health/substance abuse instruments. Following the survey, the committee identified a number of screening and assessment instruments—including tools that addressed mental health/substance abuse as well as delinquency-related risks/needs—that could be used by juvenile probation offices across the Commonwealth.[7]

With the Research Committee's preliminary work already under way, the Mental Health/Juvenile Justice Workgroup set as one of its first tasks the development of a behavioral health screening and assessment process for county juvenile probation departments. A Screening and Assessment Subcommittee was created and charged with examining and resolving issues involved in instituting such a process. The group coordinated two statewide training sessions on screening and assessment—including one in May 2005, in which Thomas Grisso, co-author of the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2), presented to over 120 juvenile justice professionals, representing over half of Pennsylvania's counties; and another in January 2006, in which practitioners in the state who were using the instruments recommended by the Chief's Research Committee met to share their experiences.

Since 2000, in a separate initiative under the Mental Health Assessment of Youth in Detention Project, youth admitted to Pennsylvania's secure juvenile detention facilities have been screened for mental health problems using the MAYSI-2. In addition to helping identify individual youth who need immediate follow-up attention, data from the project are

being used to give juvenile justice planners and decision-makers a sense of the aggregate behavioral health needs of the detention population. The MAYSI-2 was selected as the behavioral health screening instrument to pilot in juvenile probation departments for the same reasons it was successful in the Detention Project and established consistency between components of the juvenile justice system. These reasons included:

- The MAYSI-2 has been found to be "valid and reliable" for its intended purpose. There have been multiple scientific studies conducted on its use.
- It correlates reasonably well to more sophisticated assessment/ evaluation/diagnostic tools and allows cases to be prioritized. It can be used to "triage" significant volumes of cases for more in-depth and expensive interventions.
- It is relatively easy to administer as it is a self-report instrument and takes approximately 15 minutes to complete.
- It does not require clinical staff to manage or interpret the results. Training needs are minimal.
- It is inexpensive. Other than an initial cost for software, there is no ongoing "per use" fee.
- The instrument is designed in such a manner that data can be collected to inform policy and resource decisions at local and state level.
- And very importantly, the instrument is accepted "across" systems and enables the behavioral health and juvenile justice system to establish a common language.

PROBATION SCREENING PILOT PROJECT: PARTICIPATING COUNTIES

Due to a high level of county interest in the MAYSI-2 pilot project, implementation was divided into three stages.

Phase 1 counties include:

Adams, Blair, Butler, Cambria, Huntingdon, Jefferson, Lawrence

Phase II counties include:

Clarion, Columbia, Indiana, Montour, Tioga, Wayne

Phase III counties include:

Fulton, Lancaster, Venago

For more information on the MAYSI-2 Mental Health Screening Pilot Project, contact Alan Tezak (alantezak@comcast.net) or Keith Snyder (ksnyder@state.pa.us).

Over 20 Chief Probation Officers responded to the initial email from the MH/JJ Workgroup chair, requesting volunteers for the pilot project. To accommodate the response, the project was split into two phases. Phase I began in March 2007 with 14 counties participating; Phase II, with 6 additional counties, began in September 2007. Another three counties have since agreed to participate in the initiative. (See sidebar, "Probation Screening Pilot Project: Participating Counties.")

Critical to building a functional and sustainable screening and assessment process was acquiring the support and active involvement of local officials responsible for various aspects of the behavioral health and juvenile justice systems. It was recommended that counties establish or use existing groups, appropriate to their respective county and under the leadership of the juvenile court, that would include representation from juvenile probation, Children & Youth, MH/MR, substance abuse treatment, managed care, the district attorney and public defender, victim advocate, education, and families. This group would guide the development of the screening and assessment process; establish how information would be used and by whom; assess and monitor existing services; and identify needed services and advocate for the development of these services.

The Screening and Assessment Subcommittee created a Pilot Site Reference Guide, including the MH/JJ Joint Policy Statement, an implementation checklist, recommended protocols for a screening program and data collection, and a formal participation agreement. With funding from PCCD, the pilot counties received laptops, MAYSIWARE software and training as well. After registering and installing the software, the counties implemented the screening process in their juvenile probation departments. Each juvenile probation department chose at which point in the juvenile justice system it would administer the MAYSI-2. Most chose to screen at intake.

Phases I and II of the MAYSI-2 pilot project are currently under way. A User's Group of participants has been

established. The group meets by conference call on a monthly basis to share problems they've encountered and progress they've made.

The MH/JJ Workgroup is documenting the behavioral health screening practices and protocols instituted by the pilot sites, and plans to develop and distribute local and statewide data reports on MAYSI-2 results and implications. In addition to the standard demographic data collected by MAYSIWARE, the Screening and Assessment Subcommittee is interested in collecting information on current probation status and prior history with other child-serving systems. The Subcommittee is also investigating a more in-depth data collection process that would incorporate follow-up questions such as: Was an assessment or clinical evaluation indicated by the MAYSI-2 results? Did the youth receive an assessment, clinical evaluation or other service? Was there a referral to treatment? Did the youth complete treatment services? If determined useful, these additional data elements would eventually be incorporated into the Juvenile Case Management System (JCMS) used in most of Pennsylvania's 67 counties.

Continuum of Services

In order to respond adequately to behavioral health needs identified in the screening and assessment process, the juvenile justice system must have access to a continuum of services—including diversion, crisis intervention, and evidence-based treatment services—as well as guidelines for choosing among them. Ideally, at-risk youth with behavioral health needs should be identified and treated by other child-serving systems before juvenile court involvement becomes necessary. When issues of community protection and accountability to victims require the intervention of the juvenile court, procedures should be in place for identifying those youth with mental health and/or substance abuse problems, and services should be available for youth who need immediate follow-up assessments, evaluations or treatment.

The MH/JJ Workgroup formed four subcommittees to address the need for an array of community-based behavioral health treatment services for youth: Diversion, Short-Term Interventions and Crisis Management, Evidence-Based Treatment, and Family Involvement. Each subcommittee includes members of the state MH/JJ Workgroup, as well as professionals recruited from outside agencies with knowledge and/or interest in the work of each.

The Diversion Subcommittee is tasked with finding ways to divert[8] appropriate youth with mental health and/or substance abuse problems out of the juvenile justice system and into community-based treatment services. The Diversion Subcommittee's objectives include creating uniform criteria and protocols for diverting youth with behavioral health problems away from the juvenile justice system and into treatment (consistent with the goals of community protection and accountability to victims), providing training sessions in counties throughout the state to present and discuss the Subcommittee's vision of diversion, and identifying points in the juvenile justice system where it may be appropriate to divert youth into treatment services.

As part of documenting the current availability of diversion services and resources for youth and to investigate the existence of any formal diversion processes within county juvenile probation departments, the Diversion Subcommittee surveyed the counties on their diversionary polices and practices. The survey, sent to juvenile court judges, probation officers, prosecutors, defense attorneys, law enforcement, children and youth system administrators, mental health administrators, and school officials, included questions on the following:

- The existence of a diversion policy within the county,
- Where in the system youth are diverted,
- What (if any) instruments/tools are used to screen and/or assess youth for appropriateness of diversion,
- Services youth are diverted/ referred to, and
- Barriers to implementing diversion practices in the county.

The results (based on 117 responses from all but four counties) indicated a lack of formal, written diversion policies in general, and few policies specifically directed at youth with behavioral health needs. Most diversion was reported to occur at the intake stage. The most commonly reported screening instrument used was the MAYSI-2. Commonly reported diversion services included youth aid panels, community service, mental health and drug and alcohol counseling, "reality tours" of adult correctional facilities, anger management classes, and parent education classes. And the most commonly cited barriers to implementing diversion included the absence of funding and interagency collaboration.

The Short-Term Interventions and Crisis Management Subcommittee is focusing on making sure adequate services are available to youth in detention who need immediate crisis intervention services and those whose MAYSI-2 screening results

THE FUNDAMENTALS OF A COMPREHENSIVE MODEL SYSTEM
EXCERPT FROM COMMONWEALTH OF PENNSYLVANIA MH/JJ JOINT POLICY STATEMENT, SEPTEMBER 2006

Screening and Assessment

1. Mental health and substance abuse screening is available as needed at key transition points in the juvenile justice system to identify conditions in need of immediate response.
2. Instruments used for screening and assessment are standardized, scientifi cally-sound, contain strong psychometric properties, and demonstrate reliability and validity for identifying the mental health and substance abuse treatment needs of youth in the juvenile justice system.
3. Safeguards ensure that screening and assessment is used to divert youth out of the juvenile justice system and into mental health and/or substance abuse treatment when appropriate, and information and/or statements obtained from youth are not used in a way that violates their rights against self-incrimination.
4. All youth identified as in need of immediate assistance receive emergency mental health services and substance abuse treatment.
5. All youth identified as in need of further evaluation receive a comprehensive assessment to determine their mental health and substance abuse treatment needs.
6. Youth are not subjected to unduly repetitive screening and assessment.
7. All personnel who administer screening and assessment instruments are appropriately trained and supervised.

Continuum of Services

Diversion

8. Youth and their families have timely access to evidence-based treatment in their communities, such that youth do not have to enter the juvenile justice system solely in order to access services or as a result of mental illness and co-occurring substance abuse disorders.
9. Diversion mechanisms are in place at every key decision-making point within the juvenile justice continuum such that youth with mental health needs and co-occurring substance abuse disorders are diverted from the juvenile justice system whenever possible and when matters of public safety allow, including into the dependency system as appropriate.
10. Juvenile justice professionals, including judges, prosecutors, defense attorneys and probation officers, receive training on how youth with mental health and co-occurring substance abuse disorders can be diverted into treatment.
11. Youth who have been diverted out of the juvenile justice system are served through effective community-based services and programs.
12. Diversion programs are evaluated regularly to determine their ability to effectively and safely treat youth in the community.

Short-Term Interventions and Crisis Management

13. Secure detention facilities and shelter care programs have services adequate to provide short-term interventions and crisis management to youth with mental health needs and co-occurring substance abuse disorders, in order to keep them safe and stable while awaiting a permanent placement.

Evidence–Based Treatment

14. Assessment data is used to develop comprehensive treatment plans for adjudicated youth as part of their disposition.

15. Representatives from all relevant child serving systems (i.e., juvenile justice, child welfare, mental health, substance abuse, education, etc.) and families engage in the development and implementation of comprehensive treatment plans.

16. If diversion out of the juvenile justice system is not possible, youth are placed in the least restrictive setting possible with access to evidence-based, developmentally-appropriate treatment services. Such services are tailored to reflect the individual needs and variation of youth based on issues of gender, ethnicity, race, age, sexual orientation, socio-economic status, and faith.

17. Qualified mental health and substance abuse personnel are in place to provide treatment to youth in the juvenile justice system.

18. In-state capacity provides support for evidence-based treatment programs and their proliferation.

19. Mechanisms are in place to continually measure and evaluate the effectiveness of various treatment modalities, as well as the quality of service delivery.

Continuity of Care/Aftercare

20. Representatives from all relevant child serving systems (i.e., juvenile justice, child welfare, mental health, substance abuse, education, etc.) and families are engaged in the development and implementation of comprehensive treatment plans to ensure continuity of care as youth move to new juvenile justice placements, appropriate aftercare when youth are released from placement to the community, and to aid in the youth's transition to adulthood.

Family Involvement

21. Families engage with all relevant child-serving systems in the development and implementation of comprehensive treatment and aftercare plans for their children.

22. All services are child-centered, family focused, community-based, multi-system and collaborative, culturally competent and offered in the least restrictive/intrusive setting as possible, and these CASSP principles are followed in all treatment planning and implementation.

Funding

23. Sustainable funding mechanisms are identified to support all services identified above as comprising the continuum of care, particularly for screening and assessment, evidence-based treatment practices, and cross-training of professionals from the various child-serving systems.

Legal Protections

24. Policies control the use of pre-adjudicatory screening and/or assessment information, as well as information gathered during post-disposition treatment, to ensure that information is not shared or used inappropriately or in a way that jeopardizes the legal interests of the youth as defendants, including their constitutional right against self-incrimination.

Source: Commonwealth of Pennsylvania, Mental Health/Juvenile Justice Joint Policy Statement, September 2006.

indicate the need for follow-up assessment or clinical intervention. The Subcommittee is concentrating on identifying local barriers to timely assessments or crisis intervention services—such as the lack of appropriate services in the community, the short-term nature of detention admissions, and reluctance on the part of mental health providers to treat juvenile offenders—and developing strategies to eliminate those barriers. The Subcommittee wants to help those detention and shelter facilities that have been successful in securing assessment and/or crisis intervention services to share that information and provide technical assistance to those who have not been successful. Additionally, the Subcommittee will explore ways to improve the ability of detention staff to provide short-term interventions to youth with mental health/substance abuse disorders, through training on crisis intervention techniques and mental health problems in adolescents.

The Evidence-Based Treatment Subcommittee is working to improve access to and the availability of evidence-based treatment services for youth involved in the juvenile justice system. Interventions are considered "evidence-based" when they have demonstrated a high level of effectiveness through rigorous research and evaluation studies, and have been successfully replicated in different settings, with different populations, and with a similar level of effectiveness. Pennsylvania uses Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Multidimensional Treatment Foster Care (MTFC) for youth in the juvenile justice system—all of which are considered evidence-based. The most common evidence-based program available in Pennsylvania is MST. Currently, there are nine licensed programs in Pennsylvania. MST programs are on the Medicaid fee schedule so Medicaid/MA dollars can be used to purchase MST services for youth. The Pennsylvania Commission on Crime and Delinquency has provided start-up funding for sites wishing to implement evidence-based "Blueprint" programs or SAMHSA model programs. [9]

Family Involvement

Parents know their children best—their histories, interests, strengths and struggles. Yet child-serving systems often exclude parents from participating in decision-making regarding their children. Sometimes the parents don't receive notice, or have language barriers or transportation issues. Sometimes they are seen as part of the problem rather than part of the solution.

Improving the level and quality of family involvement in supervision and treatment planning for children in Pennsylvania's behavioral health and juvenile justice systems can lead to better outcomes for the child and other family members. Parents who know how to navigate through the different child-serving systems can advocate for their child and can provide important information to system professionals to guide treatment planning.

Pennsylvania has acknowledged the need for increased and meaningful parental involvement in its child-serving systems for years. Family participation is a core principle of Pennsylvania's Child and Adolescent Services System Program (CASSP):[10] "Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation…The development of mental health policy at state and local levels should include family representation."

The MH/JJ Workgroup's Family Involvement Subcommittee was established to increase the participation of families in the supervision and treatment of youth involved in the mental health and/or juvenile justice systems. The specific goals of the Subcommittee include increasing public awareness of the importance of family involvement in the mental health and juvenile justice systems; identifying ways to increase the use of practices that enhance family involvement in supervision and treatment planning; and educating Chief Juvenile Probation Officers on how to include families of youth in the juvenile justice system as important participants in the Integrated Children's Services Planning Initiative.

One of the primary activities of the Family Involvement Subcommittee is the development of a monograph that begins to define and describe what constitutes appropriate family involvement in the context of mental health/juvenile justice system coordination. The subcommittee is led by the Mental Health Association in Pennsylvania and is actively working with the Balanced and Restorative Justice Implementation Committee of the Pennsylvania Council of Chief Juvenile Probation Officers, which has identified Family Involvement as a primary goal in its strategic plan.

Funding

Creating comprehensive behavioral health services and supports can be expensive. Paying for existing services and programs already requires a degree of creativity from the

counties. Implementing new policies or practices and enhancing existing services to youth and their families will require even more money. To make the vision of the Mental Health/ Juvenile Justice Joint Policy Statement a reality will require state and local leaders to create stable funding mechanisms to ensure that needed behavioral health services in the child-serving systems are sustained.

Pennsylvania's Department of Public Welfare (DPW) provides funding for juvenile justice and child welfare programs and services in the state. Counties are required to supply matching funding. Annual "needs-based budgets" and Integrated Children's Services Plans (ICSP) are prepared by counties and submitted to DPW. Counties budget for their anticipated funding needs to provide services to children involved with the juvenile justice and child welfare systems and their families. The state, through DPW, reimburses counties a percentage of their costs to provide certain services.
In the last few years, DPW has been working to maximize federal reimbursements for services to youth and minimize the use of state and local dollars. Originally called the Integrated Children's Services Initiative, or MA Realignment, the initiative seeks ways to pay for medically necessary behavioral health treatment services through the federal Medical Assistance program for children eligible for Medical Assistance benefits.[11]

The Pennsylvania Commission on Crime and Delinquency (PCCD) also provides funding, through the federal Juvenile Accountability Block Grant (JABG) program, for state and local juvenile justice agencies and initiatives. Currently, PCCD is providing support to several initiatives related to improving services for youth involved in Pennsylvania's juvenile justice system, including funding for MAYSIWARE, laptops and printers for the MH/JJ Workgroup's Probation Screening Pilot Project, and funding for new and continuing evidence-based programs.

The state MH/JJ Workgroup has achieved its objective of having mental health/juvenile justice coordination as a stated goal in DPW's Integrated Children's Services Plan (ICSP). The FY 2008-09 ICSP Guidelines, issued in mid-May 2007, recommends that all counties promote policies and practices that allow for the early identification of youth with mental health and co-occurring substance abuse needs; appropriately divert such youth out of the juvenile justice system; and refer youth to evidence-based treatment.[12] In addition, all counties were required to complete a Mental Health/Juvenile Justice Organizational Self-Assessment, in which they rated their current practices and procedures in relation to the goals of the Mental Health/Juvenile Justice Joint Policy Statement. The intent of the Mental Health/Juvenile Justice Organizational Self-Assessment was not only to gather information on how counties perceived they operate in relationship to the MH/JJ Joint Policy Statement, but to create a framework to conduct a critical assessment and generate discussion at a local level on how to improve integration and coordination services between the mental health and juvenile justice systems.

The inclusion of the Mental Health/ Juvenile Justice Organizational Self-Assessment in the ICSP signals a recognition on the part of state government leaders that effective, high-quality behavioral health services should be available to youth. Counties are now required to anticipate their needs around providing such services to youth and their families, and to request funding specifically for these services.

Legal Protections

Under the U.S. Constitution, the Pennsylvania Constitution, and the Pennsylvania Juvenile Act, youth involved in the juvenile justice system have the right to not be a witness against or otherwise incriminate themselves. Youth are not explicitly protected under Pennsylvania law, however, when they provide information about themselves during mental health/substance abuse screenings, assessments, or clinical evaluations, or during court-ordered treatment. Youth arrested for one offense (e.g., simple assault) could easily admit to other illegal behavior (e.g., drug usage) during a mental health/substance abuse screening. Currently, there is no guarantee that information volunteered by youth will not be used to bring charges against them or that the information will not become part of their records and used against them in the future.

Behavioral health screenings are designed to identify the likelihood of a mental health and/or substance abuse disorder so that the youth may be referred for further assessment or to treatment for problems that may be contributing to their delinquency. In order to achieve successful treatment outcomes, youth are encouraged to be open and honest about themselves. When youth disclose information that is subsequently used against them in the current case or in a future case, they quickly learn to not be so forthcoming on future screenings or assessments. Additionally, as defense attorneys become aware of such scenarios, they may advise their clients not to participate in voluntary

screenings and assessments and not to fully disclose information during treatment in order to ensure that their right against self-incrimination is protected.

While some states do have statutes that specifically protect youth from self-incrimination during screening and assessment,[13] Pennsylvania does not. The lack of adequate protections under Pennsylvania law around this issue was identified by the state MH/JJ Workgroup as a barrier to the effective identification and treatment of youth with behavioral health needs in the juvenile justice system. There has also been state government-level recognition of the need to protect youth's right against self-incrimination. In a June 2006 report by the Legislative Budget and Finance Committee (LBFC) of the Pennsylvania General Assembly, Pennsylvania's Mental Health System for Children and Youth, a recommendation is made for the legislature to amend Pennsylvania's Juvenile Act to address concerns about self-incrimination when youth are screened or assessed for mental health/substance abuse disorders. In addition, in a letter to the LBFC regarding the report, the Governor's Office, the Department of Public Welfare, and the Department of Education wrote of their strong support of the recommendation due to its potential to remove barriers to treatment for youth whose behavioral health issues need to be addressed.

The state MH/JJ Workgroup's Legal Protections Subcommittee has drafted language to amend Pennsylvania's Juvenile Act to protect youth against self-incrimination when providing information during screening, assessment, and evaluation.[14] To date twenty key state organizations/ constituencies, including the Juvenile Court Judges' Commission, the Pennsylvania District Attorneys Association, the Pennsylvania Council of Chief Juvenile Probation Officers, the Mental Health Association in Pennsylvania, the Northeast Juvenile Defender Center, the Pennsylvania Community Providers Association, the Pennsylvania Department of Public Welfare, the Pennsylvania Psychiatric Society, the Pennsylvania Psychological Association, have endorsed the language of the proposed legislation, which provides that incriminating statements made by or information obtained from a youth during behavioral health screening, assessment and evaluation would be inadmissible on the issue of guilt in a later delinquency or criminal proceeding. The legislation (SB 1269) was introduced in December 2007, and was voted out favorably by the Pennsylvania Senate in March of 2008.

Until the law changes, jurisdictions interested in protecting youth's rights during screening, assessment, or evaluation can develop a memorandum of understanding (MOU). The MOU is created by the agencies involved in the supervision and treatment of youth, and serves as a standing agreement as to the permitted disclosures and uses of potentially self-incriminating information obtained from those youth. (See sidebar, "Protecting Juveniles' Rights through MOUs.")

PROTECTING JUVENILES' RIGHTS THROUGH MOUs

Counties can address concerns about the possibility of self-incrimination in the screening, assessment, and treatment of court-involved youth by creating a memorandum of understanding (MOU) between the agencies involved in the process. An MOU specifies which types of information disclosed during screening, assessment, evaluation, and treatment can and cannot be shared between the parties involved in the juvenile's supervision and treatment.

A suitable template for an MOU is contained in *Protecting Youth from Self-Incrimination when Undergoing Screening, Assessment and Treatment within the Juvenile Justice System*, by Lourdes M. Rosado, Esq. And Riya S. Shah, Esq., of the Juvenile Law Center in Philadelphia. The Juvenile Law Center has made the MOU template available online at http://www.jlc.org/publications/3/protecting-youth-from-self-inc/.

Work in Progress

Realizing the vision of the Mental Health/Juvenile Justice Joint Policy Statement—and ensuring that the behavioral health treatment needs of youth in Pennsylvania's juvenile justice system are appropriately addressed—is not going to happen all at once. Pennsylvania's "comprehensive model system" is likely to be a work in progress for a long time to come. For more information on how the work is progressing, and how you can participate, contact Keith Snyder, Chair of the state MH/JJ Workgroup, at ksnyder@state.pa.us.

Endnotes

[1] For example, among Pennsylvania juveniles in detention, more than 70% showed signs of mental or emotional distress warranting further attention—including about one in five who admitted to thoughts of harming themselves and one in three who reported drug or alcohol use that met diagnostic criteria for a substance abuse disorder. To view *Mental Health Needs in Pennsylvania's Secure Juvenile Detention Population* and *What Do We Know About the Mental Health Needs of Pennsylvania's Youth In Detention*, visit the Juvenile Detention Centers Association of Pennsylvania's website at http://dsf.pacounties.org/jdcap/site/default.asp

[2] See Legislative Budget and Finance Committee, "Pennsylvania's Mental Health System for Children and Youth," June 2006; "Managed Care and Pennsylvania's Juvenile Justice System, Recommendations of the Juvenile Advisory Committee's Managed Care Subcommittee, December 1998;

[3] Thomas Grisso. (2007). *Progress and Perils in the Juvenile Justice and Mental Health Movement*. Journal of the American Academy of Psychiatry and the Law 35:158-67.

[4] *Ibid.*

[5] James Bonta and D.A. Andrews. (2007). "Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation," downloaded from www.publicsafety.gc.ca/res/cor/rep/risk_need_200706-eng.aspx.

[6] Thomas Grisso and Lee Underwood. (2004). *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[7] Two screening instruments, the MAYSI-2 and the Problem-Oriented Screening Instrument for Teenagers (POSIT), were identified. Four assessment instruments, the Child and Adolescent Needs and Strengths-Juvenile Justice (CANS-JJ); the Intervention Needs and Competency Assessment (INCA); the Washington State Juvenile Court Assessment (WS-JCA); and the Youth Level of Service-Case Management Inventory (YLS/CMI) were identified.

[8] Since the term "diversion" means significantly different things to different people, one of the first tasks taken on by the Diversion Subcommittee was to decide on a definition that could be used to guide the Subcommittee's work. Diversion, according to this definition, is a partnership between behavioral health, education and juvenile justice systems that promotes opportunities for youth charged with delinquent acts or summary offenses, or at imminent risk of being arrested/charged, to avoid an adjudication of delinquency/conviction by providing appropriate needs-based interventions in accordance with the principles of balanced and restorative justice.

[9] See *Blueprints for Violence Prevention Model Programs and Promising Programs*, Center for the Study and Prevention of Violence, University of Colorado at Boulder (http://www.colorado.edu/cspv/blueprints/index.html). Evidence-based programs and practices identified on the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices are available online at http://nrepp.samhsa.gov/.

[10] PA CASSP is a training and technical assistance institute that advocates for a comprehensive mental health system of care for children and adolescents with serious mental health problems and their families (http://pacassp.psych.psu.edu/)

[11] The March 2008 PA Juvenile Justice Plan and Delinquency Prevention Plan submitted to the Governor by the Juvenile Justice and Delinquency Prevention Committee of PCCD included the following recommendation: "That the Governor direct the JJDPC, in conjunction with key stakeholders, to complete an analysis of the overall impact Medicaid Realignment has had on the juvenile justice system."

[12] Department of Public Welfare, Commonwealth of Pennsylvania, Bulletin 2007-1, *FY 2008-09 Integrated Children's Services Plan Guidelines* (pp. 4-5).

[13] States with statutes and court rules that protect youth's right against self-incrimination in these situations include Connecticut, Iowa, Maryland, Missouri, and Texas. See Rosado, L.M. & Shah, R.S. (2007) *Protecting Youth from Self-Incrimination when Undergoing Screening, Assessment, and Treatment within the Juvenile Justice System*. Philadelphia, PA: Juvenile Law Center. Available online: http://www.jlc.org/publications/3/protecting-youth-from-self-inc/.

[14] For more information on the draft amendment, contact Lourdes Rosado, Senior Attorney, Juvenile Law Center at lrosado@jlc.org or (215) 625-0551, or Keith Snyder, Deputy Director of the Juvenile Court Judges' Commission and Chair of the state MH/JJ Workgroup, at ksnyder@state.pa.us or (717) 787-5634.

PENNSYLVANIA PROGRESS is a publication of the National Center for Juvenile Justice–the research division of the National Council of Juvenile and Family Court Judges.

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Production Editor: Kristy Connors
Date of Publication: August 2008

Suggested Citation: Zawacki, S, Torbet, P, and Griffin, P. (2008). "Addressing the Behavioral Health Needs of Court-Involved Youth." *Pennsylvania Progress*. Pittsburgh, PA: National Center for Juvenile Justice.

This project was supported by subgrant 2006/2007-J-04-18673 awarded by the Pennsylvania Commission on Crime and Delinquency (PCCD). The awarded funds originate with the Office of Justice Programs, U.S. Department of Justice. Points of view or opinions contained within this document are those of the author(s) and do not necessarily represent any official position, policy or view of PCCD, the National Council of Juvenile and Family Court Judges or the U.S. Department of Justice.

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