

# NCCD FOCUS

## A Survey of Mental Health Care Delivery to Youth in the California Juvenile Justice System: Summary of Findings

Christopher Hartney  
Theresa McKinney  
Laura Eidlitz and Jessie Craine

### Introduction

From April through September, 2003, NCCD contacted 51 California county probation departments and 35 mental health departments\* to assess how each county's probation department identifies, assesses, and provides care to youth with mental health issues. This is a preliminary report as the interviews are ongoing; a final report will be complete at the end of 2003.

In all but a few probation departments, we spoke with the Chief Probation Officer or the director or manager of the juvenile division. Likewise, in all but a few cases in mental health departments, we spoke with the director of mental health, the director of children's mental health, or a program manager within the children's division.

The focus of the interviews was on youth in detention (predominantly juvenile halls, but also camps and ranches), but efforts were made to also collect information on youth in out-of-home placement and field supervision. For purposes of comparison, the counties were grouped into small (total populations of fewer than 100,000), medium (between 100,000 and 500,000), and large (greater than 500,000). Twenty of these counties are small, 16 are medium, and 12 are large.

\*NCCD attempted to contact every Mental Health Director and Chief Probation Officer in California. Two mental health and three probation departments declined to participate. Others that are not included in these results were not contacted successfully.

### The Numbers

Interview respondents were asked to estimate the number of youth in the various levels of their systems in a typical month and the percentages of those youth with mental health problems. Most interviewees felt that accurate numbers were difficult to report due to such factors as definitions of mental health problems, computerization, agency roles, and lack of a mandate for data collection.

#### *Number of Youth in the Juvenile Justice System*

Counties have an average of 122 youth in detention in juvenile hall in a typical month, with small counties averaging 13 youth, medium counties 66 youth, and large counties 379 youth.

Counties have an average of 81 youth in detention at a camp or ranch in a typical month, with small counties averaging 2 youth, medium counties 17 youth, and large counties 330 youth.

Counties have an average of 136 youth in out-of-home placement in a typical month, with small counties averaging 13 youth, medium counties 46 youth, and large counties 480 youth.

Counties have an average of 1232 youth in a typical month under field supervision, with small counties averaging 152 youth, medium counties 507 youth, and large counties 4088 youth.

## Number of Youth in the Juvenile Justice System with Mental Health Problems

County representatives reported that, on average, 42% of youth in detention, 59% of youth in placement, and 33% of youth under field supervision have a mental health issue serious enough to require treatment or services.

Approximately 77% of youth in detention are considered to have substance abuse problems, 76% of youth in placement, and 66% of youth under field supervision.

On average, 23% of youth in detention, 32% of youth in placement, and 18% of youth under field supervision are prescribed psychotropic medication.

On average, counties reported that 29% of youth in detention, 44% of youth in placement, and 18% of youth under field supervision have an actual diagnosis of a major mental health issue.

On average, 24% of youth in detention, 28% of youth in placement and 16% of youth under field supervision have some other indication of severe mental illness.

## Key elements of service delivery: How well are they working?

### Brief Screenings

The counties' probation departments reportedly give brief or preliminary screening for mental health to an average of 86% of incoming youth in a typical month, with an average of 96% of juvenile hall youth in large counties, 89% in medium counties, and 77% in small counties.

### In-depth Psychological Assessment

In-depth psychological assessments, typically administered while youth are in juvenile hall, are reportedly performed on approximately 14% of youth in an average month: 9% in small counties, 12% in medium counties, and 24% in large counties.

Mental health professionals (psychiatrists, psychologists, or social workers) were reported to perform the assessments by a majority of, but not all, counties. In several counties,

*The staff of mental health departments in counties of all sizes commonly expressed concern about court consultations and recommendations. They are often apprehensive that the results of psychological tests and evaluations may be used against the juvenile offender, and some staff refused to become involved with the court process. This speaks to a difference in perspective—whereas a probation department's mandate is community safety or punishment, thus, considering youth as offenders or detainees, the mental health department is inclined to consider these youth as patients, thus focusing on the treatment of mental health issues.*

who performs in-depth assessments is determined by staff availability as much as level of training.

### Case Planning

Nearly all county mental health agencies undertake case planning on both a short-term and an ongoing basis. Among large counties, mental health clinicians are typically singularly responsible for case planning, consulting only informally with probation staff on individual cases. In many medium and small counties, cases are planned by multiagency teams composed of mental health clinicians, probation officers, child welfare services staff, and school district personnel.

Funding for case planning comes from a variety of sources, including Medi-Cal and Healthy Families, grants from Services, Training, Officers and Prosecutors (STOP), Substance Abuse and Mental Health Services Administration (SAMHSA), and Children's Systems of Care (CSOC). A few counties had received support from Challenge Grants, but reported that these were not renewed in 2003.

### Available Psychiatrist

Overall, 90% of probation departments reported that a psychiatrist is available for detained youth. One hundred

percent (11 of 11 responding) of large counties reported having a psychiatrist available, 93% (14 of 15 responding) of medium counties, and 80% (14 of 15 responding) of small counties with juvenile halls. *How available are they?* is another question. Eight counties reported that a psychiatrist is never on site, 10 reported that a psychiatrist is on site between once a week and once a month, 6 reported that a psychiatrist is on site between 2 and 4 times a week, and just 8 counties reported that a psychiatrist is on site daily.

### *Mental Health Staff Training*

Over one-third (38%) of counties reported that non-mental health professional staff who work directly with youth receive little if any additional training in mental health issues beyond what is provided by the Board of Corrections-mandated training (which only minimally addresses mental health issues).

Representatives from 20 counties felt that their training in mental health-related issues is effective, 9 felt that it is effective but that the county could use more, 2 felt that it is not effective, and 1 felt that it depends on the trainer.

### *Enough Staff*

Almost two-thirds (61%) of probation departments and the vast majority of mental health directors reported not having enough staff for handling the number and severity of mental health issues their systems see.

Sixteen probation departments named staff turnover (especially staff that work directly with youth with mental health issues) as an issue, though some county representatives speculated that difficult economic conditions in the state have made it easier to retain staff.

### *Relationship Between Probation and Mental Health*

When asked to describe the role and effectiveness of the relationship between probation, county mental health, and/or private providers in the county's approach to juvenile justice youth with mental health care needs, 35 counties characterized the relationship as good to excellent.

Most probation departments (40 of 47) were generally satisfied with the level of cooperation between probation and mental health departments or private providers and 38

of 42 counties reported that the involved youth benefit or improve from this collaboration. Still, a common set of issues was reported by most probation departments, including funding issues, and concerns relating to administration, philosophy, time delays, qualifications, collaboration, and level of service.

### *Automated Data Collection*

Thirty-eight of 45 counties reported that they collect automated data at least partially, but only 7 counties reported that the level of computerization of records in the probation department was adequate to meet their needs.

## *Obstacles, Gaps, and Recommendations*

### *Appropriate Selection of Services*

Thirty of 45 counties reportedly do *not* have an appropriate selection of services in terms of type, quality, or capacity available for youth with mental health issues: 68% of small counties, 56% of medium counties, and 80% of large counties.

The most common unmet needs were having enough locked facilities for seriously mentally ill youth, residential or other substance or alcohol abuse centers, and a general increase of staff. Other needs were increased outpatient care, family therapy, follow-up care, early intervention, parenting programs, increased services in general, more training for staff, and policy reform at the state level.

Most counties responded that these services were missing because of lack of funding or resources. Five counties mentioned the lack of appropriate staff, 4 counties noted the size of the county or the distance of facilities, 4 counties noted a societal or governmental shifting of priorities away from mental health issues, and 3 counties mentioned difficulty in staff recruitment or staff turnover rates.

Over half of the large and medium counties have no individual therapy sessions available to youth in juvenile hall. Some counties have special group therapy sessions for youth with specific issues, such as substance abuse or sex offender status.

Three northern California rural counties have dealt with the lack of child psychiatrists on staff by setting up tediagnosis and medication maintenance arrangements with medical centers outside their respective counties.

### *Gaps in the Continuum of Services*

The most frequently identified gap was in residential care, with 17 counties identifying the need for various residential treatments. Counties listed various specific sub-populations requiring but often not receiving residential care, including youth with mental health issues, severely disturbed youth, substance abusers, sex offenders, females, transitional youth, and foster children.

Other key gaps in services commonly mentioned included a need for follow-up or rehabilitation services, early intervention or preventative programs, early mental health and needs screening, substance abuse services, family-focused services, culturally competent services, and increased capacity. In a few counties, medications are not permitted in detention facilities, and youth there must curtail their medication regimen. In others, only youth with private doctors can continue medication use.

At least 20 counties reported that gaps in interventions and services harmed the youth. Many counties identified inappropriate placements, either in juvenile hall, CYA, or other placements, as well as extended times in juvenile hall or out-of-home placements as negative effects of these gaps in services. Additionally, youth were bounced from placement to placement, were given out-of-home placements farther from home, faced increased family problems at home, returned home after placement to often unhealthy environments without follow-up, and were poorly prepared for aging-out of the system. Other negative effects included more youth entering the system, higher recidivism, increased behavior problems and violence in custody, and increased escapes.

Counties most commonly attributed these gaps to insufficient funds or resources for costly services. Other contributing factors included location barriers or lack of facilities, lack of

qualified staff, a lack of commitment or motivation in the community, too little collaboration, and a lack of recognition of the importance of mental health services.

### *Strength of County Systems*

The most common strength of each county's system was reported as good collaboration and care, and dedication on the part of leadership and staff to the well-being of youth. Other strengths noted were good communication, efforts at early intervention, individualized approaches, and good intervention programs. Counties also listed supportive Boards of Directors, good understanding of youth needs, lots of resources, good assessment, and a family focus.

### *Needed Improvements of County Systems*

In addition to closing gaps in services and increased residential placement capacity, the most frequently desired improvement was to increase funding or to make funding more flexible or stable. Other commonly desired improvements included expanded services, including expanded academic services, more prevention efforts, increased services specifically for severely emotionally disturbed youth, increased substance abuse services, increased services for youth incarcerated at juvenile hall, and increased transitional or outpatient care. The need for increased residential units was expressed by 17 counties, including the need for new residential units overall, a new Juvenile Hall, residential homes for youth in foster care, and mental health residential units.

*Crisis intervention is often one of the few opportunities for youth to receive individualized attention from mental health clinicians due to the lack of availability of therapists and the transitory nature of stays in detention.*

Five counties saw the need for increased family involvement, family therapy, and a better continuum of services.

At the programmatic level, seven counties saw room for improvement with staff numbers, qualifications, and/or training. Seven responses pertained to structural changes, such as increased collaboration, better automation, and quicker response time.

## Collaboration

*Overall, most mental health directors and program managers report excellent or improving collaborative relationships with probation, education, Child Welfare Services, contracted service providers, and other agencies that deal with juvenile justice-involved youth who have mental health issues. A few of the large counties turn to collaborative efforts in part to respond to staffing shortages, as well as for program development and testing.*

*Funding sources sometimes require collaboration among agencies. Many of the directors expressed good working relationships—and good outcomes—with their partners. However, collaboration on a day-to-day, operational level presents some difficulties that are worthy of consideration. In some counties, mental health staff expressed dismay at what one director characterized as “probation’s unwillingness to reconsider the punitive approach to juvenile justice.” Others noted that breakdowns in collaborative efforts stemmed not from philosophical differences but from competition among agencies for funding. This has created an adversarial relationship between agencies that is not at all conducive to collaboration. This in turn, leads, at one extreme, to “turf wars” and conflicts over program jurisdictions. At the other extreme, agencies may adopt a “hands off” policy, becoming the “payer of last resort,” much to the detriment of the youth who need their services.*

Mental health department representatives generally agreed about the most important improvements they could make at the county level—increased use of evidence-based models and practices; better coordination with probation and other agencies; improvement in information systems infrastructure so that data on both individual and aggregate cases can be tracked and evaluated more efficiently, easing collaboration with probation departments; full integration of substance abuse and mental health services to better respond to the high incidence of co-occurring disorders among juvenile justice-involved youth; and the formation of multiagency steering committees and case management teams to improve service delivery to all youth, including those transitioning out of the system.

Finally, mental health directors called for improving community and family partnerships. Furthermore, they would develop culturally sensitive and relevant programs and services and actively recruit ethnic minority mental health professionals; develop family-oriented programs and services; and, for small, rural counties, bring acute, in-patient mental health services to the county, or at least to a regional center less than 250 miles away, as it is now in some cases.

### Strengths at the State Level

When asked about system strengths at the state level, the most frequent answer was “none” or “not much.” Counties did report several strengths, including the Juvenile Justice Crime Prevention Act (JJCPA) or other funding, cooperation among California Probation Officers, and wraparound services.

### State delivery system improvements

When asked what are the three most important improvements needed at the state level, almost half of responses were related to funding. Other responses included the need for increased mental health care or mental health facilities, the need to focus on empirically-proven programs, the need for increased technical assistance or automation assistance from the state, the need to reform or eliminate the California Youth Authority (CYA), the need for transition programs out of CYA, the need for increased training of county level staff, the need for increased prevention efforts, the need for augmented interagency cooperation, the need to give attention

to small counties, and the need for alternatives to incarceration.

Mental health directors and program managers had three common recommendations for improvement at the state level—overhaul Medi-Cal reimbursement policies, especially as they pertain to service delivery to youth in detention; dedicate stable funding streams for implementation of the Children’s System of Care and other programs; and increase utilization of evidence-based practices.

A couple of directors called for the formation of a multidisciplinary, multiagency Children’s Systems of Care Department, which would oversee all programs and services for youth in the state.

### Consequences of Budget Cuts

Probation department representatives were asked about immediate and long-term issues that they see arising due to the budget constraints and pending cuts in Sacramento. They expect a reduction in services, in particular those related to mental health care, and a set of generally negative effects on community crime and well-being—increased recidivism; increased placements in juvenile halls, CYA, jails, and hospitals; less supervision of parolees and others; the potential elimination of drug court; less emphasis on prevention; and an increase in needy youths “falling through the cracks.”

Representatives from 13 counties predicted impacts on staff including fewer staff, reduced staff training, larger case loads, increased staff burnout, increased recruitment costs, and difficulty hiring qualified staff.

#### **Creative financing vs. quality care, an example**

*Because services for youth in juvenile hall, boot camps, or ranches typically are not reimbursed by Medi-Cal or Healthy Families, due to federal eligibility criteria, many counties must rely on general funds to pay for individual and group therapy for youth in detention. Some counties simply can not make these services available to detained youth. The counties seek alternatives through intensive day treatment programs or in outpatient settings such as clinics or schools. In this way, some counties can bill services to Medi-Cal and Healthy Families, as well as subsume the costs of services as part of the operational costs of other programs. Counties that do make individual and group therapy sessions available to youth in detention typically do so through grants from JJCPA, AB 3015, EPSDT, and realignment funds.*

*Although counties are compelled to look to economical therapeutic treatments that rely on group therapy, this approach has consequences that deserve consideration. Numerous studies have shown that the group approach is often more counterproductive than not. Steiner et al. found that “...[Y]outh who participated heavily in the group activities not only had higher recidivism than those who took part in individualized and family treatments, but they also had higher recidivism than control group youth receiving no intervention...The evidence suggests that many or most of these [delinquent] youth would be better served in programs that minimize rather than mandate interaction among delinquent peers.”<sup>1</sup>*

<sup>1</sup> Steiner, H., Humphries, K., & Redlich, A. (2001). *The Assessment of the Mental Health System in the California Youth Authority: Report to Governor Gray Davis.*