Oregon State Court
Juvenile Justice Mental Health Task Force

REPORT AND RECOMMENDATIONS

January 2016

Juvenile Justice Mental Health Task Force

HON. LISA GREIF, Circuit Court Judge, Jackson County Circuit Court
HON. NAN WALLER, Presiding Judge, Multnomah County Circuit Court
Co-Chairs

Hon. Ricardo Menchaca
Circuit Court Judge
Washington County Courthouse

Iris Bell
Executive Director, Youth Development Council
Oregon Department of Education

Dr. Mark Bradshaw
Behavioral Health Medical Director
AllCare CCO

Sandy Bumpus
Executive Director
Oregon Family Support Network

Lois Day
Director, Child Welfare
Department of Human Services

Faye Fagel
Director
Marion County Juvenile Department

Joe Ferguson
Deputy Director
Jackson County Juvenile Services

Andrew Grover
Assistant Director of Oregon Operational Services
Youth Villages

Dr. Ajit Jetmalani
Director
Division of Child and Adolescent Psychiatry
Oregon Health and Science University

Mary Kane
Attorney
Youth Rights & Justice

Brendan Murphy
Trial Team Leader
Marion County DA's Office

Fariborz Pakseresht
Director
Oregon Youth Authority

Cherryl Ramirez
Executive Director
Association of Oregon Community Mental Health Programs

Lynne Saxton
Director
Oregon Health Authority

Kim Scott
Executive Director
Trillium Family Services

Staff to the Task Force:
Megan E. Hassen
Juvenile Law & Policy Counsel
Juvenile and Family Court Programs Division
Oregon Judicial Department

Angela M. Keffer
Management Assistant
Juvenile and Family Court Programs Division
Oregon Judicial Department

Special thanks to the following individuals for contributing to the work of the task force:
Amy Baker, MSW, GOHBI
Paula Bauer, Oregon Youth Authority
Dr. Margaret Braun, Oregon Youth Authority
Dr. Keith Cheng, Trillium Family Services
Anya Sekino, Youth Development Council
Dr. Whitney Vail, Oregon State Hospital

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I. Executive Summary

Nationally, it is estimated that 70 percent of youth in the juvenile justice system meet the criteria for at least one mental health disorder.[1] In Oregon, statewide statistics about how many youth come into the juvenile justice system with a mental health disorder are not available. Currently, there is no legal requirement that juvenile departments screen youth for mental health disorders when they are referred to the juvenile justice system. There are differing practices in how mental health issues are identified and dealt with according to the policies and resources in each Oregon county. The only comprehensive statewide statistics available are for the minority of juvenile justice youth who end up committed to the Oregon Youth Authority (OYA).

In recent years, Oregon judges and juvenile directors have experienced an increasing incidence of cases involving children with severe mental health needs and complex trauma histories who cannot be placed appropriately. A lack of psychiatric services, residential beds and crisis placements has led to youth being held in less than ideal settings, such as detention or in hospitals. These settings are ill equipped to help youth with significant needs, many of whom have suffered abuse, neglect, and trauma. These settings can exacerbate underlying trauma, are expensive, and are not conducive to producing positive outcomes.

Concerned that the system was not adequately serving these youth, Chief Justice Thomas Balmer convened the Oregon State Court Juvenile Justice Mental Health Task Force to study the problem and recommend solutions. The findings and recommendations contained in this report were developed by leaders of agencies in Oregon who serve youth, representing the Judicial Department, Health Authority, Youth Authority, Child Welfare, Oregon Health and Science University's Division of Child and Adolescent Psychiatry, Department of Education, Youth Development Council, the Juvenile Department Director's Association, Youth, Rights and Justice, Youth Villages, Trillium Family Services, Association of Oregon Community Health Programs, Coordinated Care Organizations, and Oregon Family Support Network.

The task force found, with limited exceptions, that mental health services provided to at risk and delinquent youth with mental health issues are frequently not adequate and not well coordinated when youth move between systems. Anecdotal evidence suggests that culturally appropriate, community based mental health and psychiatric services are in short supply statewide. The Oregon Health Authority's mapping project, expected to conclude in 2016, may provide a more complete picture of existing gaps in services. Complicating matters, no single system or entity is accountable for children, leaving some who don't fit neatly within the funding silos of allotted programs without the services they

[1] Skowyra, K., & Cocozza, J. (2007). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System. Delmar, NY: National Center for Mental Health and Juvenile Justice.

need to be successful. In addition, information about children as they move from system to system is not regularly shared for purposes of planning and treatment, resulting in a lack of continuity of care.

The majority of youth in crisis with mental or behavioral health needs who are referred to the juvenile justice system are not systemically screened for mental health issues upon entry into the system, nor are crisis and residential treatment beds readily available. As a result, current detention centers and state secure facilities for incarcerated youth are experiencing higher rates of mentally ill youth within their confines, yet are not designed for youth with serious mental health issues. Institutionalized processes for screening and diverting youth when the primary underlying issue is based on mental health or trauma to more appropriate evidence based[2] trauma informed interventions would provide youth with greater opportunities for healing and rehabilitation. Based on these findings, the task force recommends the following structural and legal changes to Oregon's child serving systems:

- All child serving systems should agree to a common set of principles by which young people and families are treated, engaged and encouraged to participate.
- The Judicial, Executive and Legislative branches should work together to create a Children's Cabinet to centralize and better coordinate the work of governmental agencies, task forces, committees and work groups that address systems reform issues.
- The legal framework for information sharing between governmental agencies and service providers needs to be built in order to allow for effective coordination of efforts between schools, law enforcement, service providers, child welfare, juvenile departments and the courts.
- Efforts need to be made to identify and treat children with mental health issues before they reach the juvenile justice system.
- Youth who are referred to the juvenile department should be screened for mental health issues and connected with appropriate services if needed.
- Juvenile departments, mental health and Coordinated Care Organizations should work together to ensure interventions that youth are referred to are producing positive outcomes.
- Additional legal protections regulating the use of psychotropic medications for youth involved in the juvenile justice system should be enacted to ensure children receive the same level of protection, regardless of which system they are involved in.
- Youth who cannot be safely maintained at home with serious mental health needs should be placed in the least restrictive trauma informed treatment setting available.

[2] References to "evidence based" in this report include evidence based programs defined in ORS 182.515 and evidence informed practices.

- Juvenile departments and the OYA should ensure that youth have adequate mental health services set up in the community when youth are released from custody. Coordinated Care Organizations should be mandated to schedule appointments with these youth prior to their release from custody to ensure adequate supports are in place when the youth returns to the community.

II. Origin and Charge of the Task Force

In 2014, Chief Justice Thomas Balmer selected a group of Oregon judges, juvenile department directors, and a representative from the Juvenile Court Improvement Program to attend a Juvenile Justice Reform Summit co-sponsored by the National Center for State Courts and McArthur Foundation. At the summit, the group was asked to identify problem areas in how youth involved in the Oregon juvenile delinquency system were handled. The most prominent and pressing problem identified was the increasing number of youth with serious mental health problems. Specifically, the following problems were identified:

- lack of timely psychological evaluations,
- inconsistent access to psychotropic medication management,
- interruptions in services caused by suspension of the Oregon Health Plan when a youth is incarcerated,
- insufficient out of home placements, and
- lack of coordination between schools, juvenile departments and juvenile courts.

In September 2014, Chief Justice Balmer assembled the Juvenile Justice Mental Health Task Force to review and assess the adequacy of mental health services provided to youth involved in the delinquency system in light of current best practices, and make recommendations regarding reform by December 31, 2015[3]. Over the course of 16 months, the task force held nine meetings, 14 subcommittee meetings, and surveyed juvenile court judges and every Juvenile Department Director in the state.[4] In addition, chart reviews of 30 youth committed to OYA were conducted for psychotropic medication prescribing practices.

[3] This deadline was subsequently extended to January 31, 2016.

[4] The results of both surveys are provided in the Appendix.

III. Findings

1. Oregon lacks comprehensive planning structures for juvenile justice reform that includes all of the necessary decision makers.

Although there are many groups in Oregon working on specific problems related to juvenile justice, there is not one group that is looking comprehensively at how best to leverage resources to produce the best outcomes for Oregon children who are involved in multiple systems. Planning is currently fragmented, and sometimes duplicative. Data regarding how children move between systems is not readily available, making it more difficult to make informed decisions about how to reform systems.

2. Juvenile departments are not uniformly screening youth for mental health issues when they enter the juvenile justice system.

There is no legal requirement in Oregon that juvenile departments conduct mental health screening on youth. As of August 2015, 37% of juvenile departments were conducting some type of mental health screening. Without screening at the front end, decisions that are made about how to process the youth's case may not adequately address underlying problems which could be fueling the youth's behavior.

At the tail end of the juvenile justice continuum, a significant number of youth who are committed to OYA have been diagnosed with mental health disorders. According to 2014 data on incarcerated OYA youth, 94% of females and 74% of males had been diagnosed with at least one mental health disorder.

3. Juvenile departments statewide are experiencing problems finding available residential placements for youth with mental health needs.

According to a statewide survey of juvenile department directors, 86% report that residential care is difficult to access. The task force received reports from judges and juvenile departments that some youth are being held in detention because more appropriate placements are not available. One hundred percent of the juvenile judges who responded to the task force survey, and 83% of juvenile department directors, indicated the length of detention stays could be reduced if residential and crisis beds were more readily available.

Many juvenile departments report that the process to get into a placement is cumbersome, with some providers requiring that the youth be denied by other programs before considering the youth for placement. Youth with a history of assault, sex offenses or fire setting also are more difficult to place. Another reported problem is lack of a uniform assessment. Youth may be assessed, but denied by a program until a different assessment is conducted, creating more delays. Finally, lack of long term residential treatment options results in some youth bouncing from the emergency room, to detention, to a brief stabilization placement, back home and then back into the emergency room because they never received an adequate period of treatment and stabilization. In some instances, children have to be placed

out of state in order to receive the services they need, which makes it more difficult to involve the family in treatment.

> ***"Frequently, our two (for the whole county) detention beds are occupied with youth that don't have an appropriate community placement… The most common struggle seems to be this concept of not referring a youth to a particular type of program until other programs have denied them. This really slows the process and leaves youth in detention beds for an inappropriate amount of time… Detention has become a type of secure shelter placement at times as a result."***
> *Juvenile Department Director, August, 2015*

Those whose needs can't be adequately served may fall deeper into the system. When local programs do not provide the services or level of care a youth offender needs, commitment to OYA may be the only option that preserves public safety. Seventy three percent of juvenile judges who were surveyed indicated committing at least one, and sometimes multiple, youth to the OYA in the last year primarily because there were no other options at the local level to serve the youth's mental health needs. OYA has funding for community based correctional residential programs that aren't available through all juvenile departments. In the event appropriate services can't be arranged in the community and the youth has to be incarcerated, OYA correctional facilities are currently not staffed adequately to serve youth with significant mental health needs, as discussed further under finding number five.

When no other placement can be found, a Statewide Multi-Disciplinary Committee (SMAC) will review a youth's case. The role of the SMAC is to assist in solving barriers and system problems that make it difficult to place youth. Over time, SMAC has identified a set of common characteristics of youth who are referred to SMAC. These include youth with behavioral health conditions and/or 'borderline' intellectual or functional disabilities who exhibit violent aggression, and who have a history of assault, property destruction or sex offenses. These youth consistently experience difficulties in accessing needed treatment beds because they are denied for services or placements due to not meeting eligibility criteria, behavioral expectations, or other rules regarding access to services from different systems.

4. There are insufficient emergency placements available for youth in crisis.

Juvenile departments and courts report there are an insufficient number of emergency placements available for youth who are in crisis and cannot safely be returned home. Sixty one percent of Juvenile Department Directors, and 90% of judges surveyed, indicate a need for emergency placements in their communities.

The task force also received examples from the Governor's Advocacy Office regarding complaints received about lack of placement options. Some examples include: (1) a child welfare worker had to

stay overnight at the DHS office with a child who had significant mental health needs because there were no beds in the community; (2) a hospital employee complained because a foster family dropped off two out of control children with autism at the hospital after business hours with no medical records and severe behavior problems; and (3) a child waiting for inpatient mental health treatment waited in the emergency department for three days and then had to be released home because no psychiatric beds were available.

Without adequate emergency placements available, the default is to hold these youth in detention, which can exacerbate existing problems. Once placed in detention, the district attorney or juvenile department must make a charging decision about whether to file a delinquency petition with the court. Without an appropriate place for the youth to stabilize, youth are at risk of experiencing continued trauma, escalation, and new charges.[5]

5. There is a continued need for a sufficient number of evidence based, culturally appropriate interventions for juvenile justice youth with mental health issues.

At the time of this report, the Oregon Health Authority is conducting an analysis of publicly funded mental health services throughout Oregon to determine if the services available in each community are sufficient to meet local needs. According to task force surveys, juvenile department directors and juvenile judges report a lack of availability of psychiatric services, home-based support and psychotropic medication management services. In addition, 73% of juvenile judges surveyed reported a lack of evidence based interventions in their communities. Sixty-nine percent of juvenile department directors report using evidence based programs, however, they also report gaps in services. Roughly a third of juvenile department directors noted a lack of school based mental

> ***"There needs to be someone accountable for these services. I have been extremely frustrated in trying to determine who the gatekeeper for services is. I cannot get a straight answer. The responsibilities are so scattered that everyone points a finger at someone else."***
> *Juvenile Court Judge, October, 2015*

[5] Similarly, Oregon hospitals are experiencing an increasing number of children with behavioral health challenges inappropriately waiting in their emergency departments and pediatric hospital rooms due to lack of other, more appropriate, therapeutic options. Baker, A & Jetmalani, A, (2014) Crisis Workgroup Recommendations, Children's Mental Health Increased Emergency Department Visits (provided in Appendix). In response, the Oregon Health Authority has established four pilot programs that provide qualified mental health professionals to assist families of children in the hospital emergency department with the process for accessing services, including help connecting the child and family with assessments, respite, safety planning and skill training. These programs will be monitored to determine if they are having a positive impact on the number of children waiting for placements, and the time spent waiting.

health support. Finally, 73% of judges surveyed report a lack of culturally appropriate services within their judicial districts.

Youth in detention have fewer treatment options available than youth in the community. Detention at the county level is supposed to be short term, so it makes sense that services would be limited. For example, roughly half of juvenile departments provide cognitive behavioral therapy, and only a third have medication therapies available. Dual diagnosis treatment is available for youth with substance abuse issues in some counties, however, most juvenile departments report this is only available for youth in the community.

While some mental health services are provided in OYA correctional facilities, these facilities and services are not designed or intended for youth with serious mental health issues. Correctional facilities within OYA are not designed or staffed to provide the same type of services that psychiatric residential programs provide. The focus of correctional treatment is to address identified conditions which may lead to further delinquency. Current OYA mental health counseling services, as well as psychological and psychiatric services, aren't staffed to meet the psychiatric residential level of care and should not be used as an alternative to insufficient resources in the community.

6. Mental health records do not follow the youth when they move from system to system, resulting in duplicative assessments, lack of coordination between providers and lack of continuity in services.

With limited exceptions, Oregon does not have the technological or legal infrastructure to support comprehensive data sharing between providers and systems who serve youth. Information sharing agreements have been worked out in limited circumstances through Wraparound and Crossover Programs. Juvenile department directors uniformly indicate it would be helpful to review school, child welfare, mental health, and developmental disabilities services records in order to determine appropriate responses when youth are referred to the juvenile department. The majority also believe it would be helpful to consider medical records. In practice, 54% of juvenile department directors report difficulties in accessing needed information. Almost two-thirds of juvenile judges surveyed identified continuity of care between systems as a problem.

7. When youth are incarcerated, there are problems in the continuity of mental health services.

Youth who are incarcerated are not eligible to receive Federal Medicaid dollars and therefore cannot be enrolled in the Oregon Health Plan. Consequently, health and mental health services provided to youth in detention and in OYA close custody are typically paid by state and local governments. Youth who are enrolled in the Oregon Health Plan prior to being incarcerated have their benefits suspended for their period of incarceration. While incarcerated, they receive services provided through the county juvenile department or OYA. Although Oregon Health Plan coverage is reinstated upon release, providers will not allow medical or mental health appointments to be made until the youth is actually

released. This can cause delays in receiving services, and can be problematic for youth in need of psychotropic medication management. In roughly half the cases, a youth leaving detention is not able to continue with the same provider because of the different funding streams or change in location of residency. In addition, some youth are placed on a waiting list for services upon release, may be denied service if identified as "conduct disordered," and may experience a change in psychotropic medication due to the Oregon Health Plan formulary or differing prescribing practices by new providers, all of which can create further instability upon reentry.

8. Inadequate protections are in place for juvenile justice youth who have a need for psychotropic medications.

The task force conducted a review of the legal protections for psychotropic medication prescribing for juvenile justice youth and found that the requirements vary according to the youth's placement setting. Generally speaking, the protections for children in child welfare foster care are greater than those for juvenile justice youth.

To provide additional information about current prescribing practices for incarcerated youth, OYA pulled data from 30 charts on incarcerated youth, and allowed for review by the Director of Child and Adolescent Psychiatry at the Oregon Health and Science University. The findings showed that 73% of youth were prescribed more than two psychotropic medications. In the child welfare context, the law requires a minimum of an independent annual review by a licensed medical professional, or qualified mental health professional with authority to prescribe, other than the prescriber when a child is prescribed more than two psychotropic medications.[6] In practice, child welfare cases subject to this requirement are reviewed by a child psychiatrist, consistent with the national standard of care.

In addition, 10 of the 30 cases reviewed involved the use of antipsychotic medications prescribed for reasons other than Bipolar Disorder, Autism or psychosis. These cases would also be subject to extra review if the youth was in the child welfare system pursuant to a technical assistance grant funded by the Casey Foundation. In practice, some difficult cases at OYA are flagged by the medical director for additional review. However, considering the number of cases of youth who are prescribed multiple psychotropic medications and antipsychotic medications, and the lack of uniformity of legal protections between the child welfare and juvenile delinquency systems, it is possible that a child in the legal custody of the Department of Human Services Child Welfare may not receive the same type of oversight provided by a second professional review of his or her psychotropic medications if he or she is subsequently committed to OYA.

At the county level, the majority of juvenile departments are not involved in ensuring continuity in psychotropic medication management when a youth is placed in residential or other out of home care.

[6] ORS 418.517(3)(d).

Some juvenile departments work with the youth at discharge to reinstate health insurance, obtain a supply of medication for the youth and make an appointment with the youth's prescriber. Such practices help prevent youth from destabilizing, however, they are not currently legally required.

IV. Recommendations

1. All child serving systems should agree to a common set of principles by which young people and families are treated, engaged and encouraged to participate.

The task force recommends that child serving systems should base development of policies, practices and programs on a basic set of core values and principles. These principles include:

- Mental health services in the community should be accessible.

  Youth should not have to enter the juvenile justice system solely in order to access mental health services or because of their mental illness.

- Least restrictive setting.

  Whenever possible and appropriate, youth with mental health needs should be diverted from the juvenile justice system into evidence-based treatment matched to their individual need in a community setting.

  If diversion out of the juvenile justice system is not possible, youth should be placed in the least restrictive setting possible which makes necessary accommodations for the youth's level of cognitive functioning, mental health conditions and functional impairments.

- Screening.

  Screening and treatment protocols should address the known prevalence of co-occurring mental health and substance abuse issues among juvenile justice youth at the earliest point of contact.

  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.

- Services.

  Address disparities. All mental health services provided to youth in contact with the juvenile justice system should appropriately respond to issues of gender, ethnicity, English proficiency, race, age, sexual orientation, social-economic status and faith, and

should address past disparities. Programs should strive to create a community of support for each youth and family that honors the youth and family's sense of their culture.

Trauma informed. Screening practices and services provided to youth and their families should be trauma informed and address the known prevalence of high Adverse Childhood Experiences (ACES) among the juvenile justice population.

Developmentally appropriate. Mental health services should meet the developmental realities of youth based on current science about child development.

Family[7] and youth voice. Family and youth perspectives must be intentionally elicited and prioritized during the development and delivery of treatment and reentry services. Inclusion of supports for the youth are appropriate to the extent ground rules can be followed with appropriate coaching, to allow for strength based planning with the best interests of the youth as the primary driver.

Respect. Individuals should be treated respectfully, compassionately and effectively in a manner that recognizes, affirms and values the worth of youth, families and communities. Systems should provide a means for eliciting feedback regarding whether the youth and family are being treated respectfully, compassionately, effectively, and with dignity.

Strength-based. Treatment plans should be asset driven and build on the youth's strengths and updated regularly to capture shifts in youth presentation and development while in care.

Evidence-based. Youth should have access to the most current appropriate evidence-based treatment matched to their individual need, regardless of where they are placed. Services and strategies aimed at identifying and treating youth with mental health needs in the juvenile justice system should be routinely evaluated in terms of client and family level outcome analysis. Effective interventions should demonstrate youth are productively engaged in life at later intervals (12 to 24 months post discharge), and that any measurement of outcome takes into account the youth's and family's perception of their progress.

[7] *"Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adoption, legal or *social relationships*. Family also means any natural, formal *or informal support persons identified as important by the individual.*

Attachment. Any treatment plan should recognize a youth's need for attachment to a primary caregiver, and should help maintain or build relationships to ensure the youth has lasting supports in the community.

- Community responsibility.

  Multiple systems bear responsibility for these youth. While at different times a single agency may have primary responsibility, these youth are the community's responsibility and all responses developed for these youth should be collaborative in nature, reflecting the input and involvement of mental health services, juvenile justice, and other systems. Services provided to the youth and family should be integrated to ensure results for the client, and to avoid duplication and conflicting requirements.

- Data collection and analysis.

  All systems should collect, track, analyze and share data to ensure the effectiveness of interventions, to eliminate gaps in data collection, and to stay informed about what works.

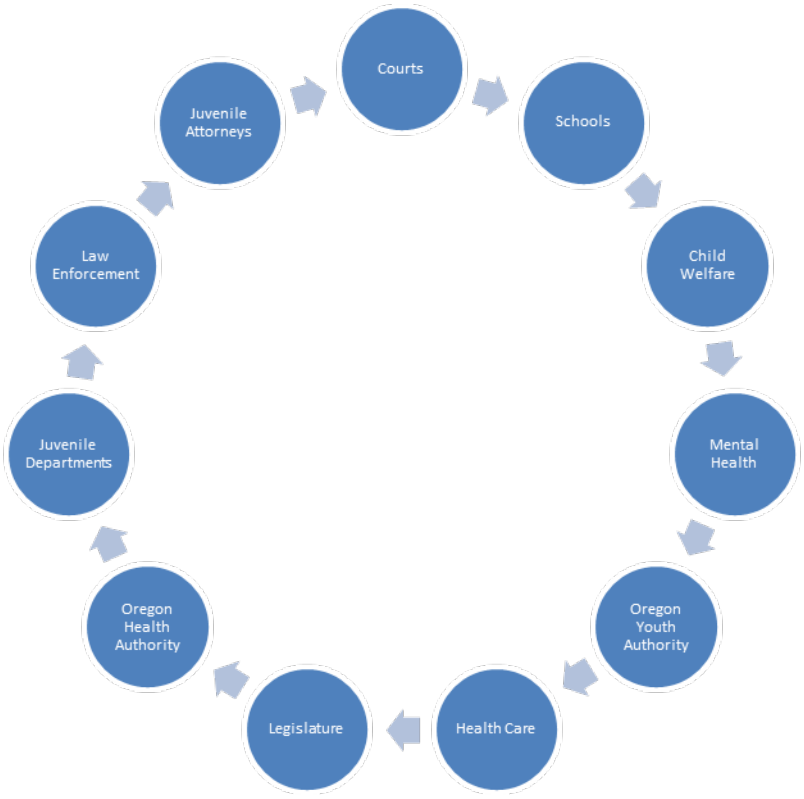
- Youth Services Wraparound Initiative

  The core values and principles of the Youth Services Wraparound Initiative provided in ORS 418.977 should also serve as a guide to youth serving agencies.

2. *The Judicial, Executive and Legislative branches should work together to create a Children's Cabinet to centralize and better coordinate the work of governmental agencies, task forces, committees and work groups that address systems reform issues.*

In order to move forward with reform to the juvenile justice system, basic structures must exist to adequately coordinate planning among government agencies and child serving systems. One of the challenges that exist in Oregon is the decentralization of juvenile justice agencies. The vast majority of cases are resolved by county juvenile departments, at the county level. Within each county are varying levels of funding and community resources to support youth. Any statewide effort to reform juvenile justice must involve all three branches of government, representatives from local government, community mental health services, Coordinated Care Organizations, and others.

A Children's Cabinet dedicated to juvenile justice issues should be formed to coordinate reform efforts on a statewide level. Various committees and groups already working to improve how services are delivered to at risk and delinquent youth need to be coordinated through the Children's Cabinet to reduce duplication, increase information to all stakeholders and better leverage Oregon's resources. This group should be convened and appropriately staffed by the Governor's Office, and should consist of representatives from the following:



As part of this effort, a data team should be assembled with representatives from all systems. The team should agree on and use a common terminology and set of measurements. In order to understand how services can be appropriately leveraged, a mental health prevalence study needs to be conducted of youth who intersect with the juvenile justice system. In addition, analysis needs to be conducted of how these youth are ending up in the system to determine if: (1) earlier interventions could have prevented juvenile justice involvement; and (2) whether there are cases that are inappropriately referred to juvenile departments. This analysis will help inform whether Oregon can be providing more appropriate interventions for youth whose primary problem is an underlying mental health disorder.

3. The legal framework for information sharing between governmental agencies and service providers needs to be built in order to allow for effective coordination of efforts between schools, law enforcement, service providers, child welfare, juvenile departments and the courts.

In order to allow for effective cross-system collaboration, procedures should be put in place to ensure that mental health records follow youth when they move within and between education, mental health,

child welfare and juvenile justice systems. The overarching goal is to ensure assessment, services and treatment are provided in a coordinated way between systems, and to avoid the duplication of services. In some limited settings, such as Wraparound and Crossover Programs, information sharing agreements have been put in place allowing better coordination between mental health and governmental agencies that provide services and case planning to youth. However, such practices are not widespread. There are a myriad of state and federal laws governing the release and use of mental health records, and a lack of general knowledge about what can and cannot be released.

An information sharing guide detailing state and federal law should be developed, along with a uniform release for use by all state agencies, mental health and health care providers. The task force recommends the guide follow a similar, easy to read format as those developed in Arizona and Washington[8]. These guides provide specific information about who can release what, according to a person's role within the system. The task force recommends that a limited duration position be funded within the Department of Justice to develop the guide, convene interested groups to develop a uniform release, and to identify provisions in Oregon law that unnecessarily impede effective information sharing practices. It is more cost effective to have one agency conduct the needed legal research for such a project, than to have multiple agencies trying to navigate the legal landscape using their own resources.

Once the legal framework for information sharing in Oregon is established, the task force recommends any information shared be used only for purposes of delivering appropriate services and rehabilitation of the youth. Information provided to schools, law enforcement, juvenile departments and mental health professionals by the youth or family for purposes of mental health screening and assessment should not be used as evidence, without the consent of the youth, for purposes of establishing whether the youth is subject to the jurisdiction of the juvenile court. The completed assessments and screening tools should also be protected from admission at the time of adjudication. However, the provision in ORS 419C.411(4)(f) allowing the court to consider the youth offender's mental, emotional and physical health should be retained to ensure appropriate disposition of the youth. The task force also does not intend to change the admissibility of reports filed pursuant to ORS 419C.386 for purposes of a determining a youth's fitness to proceed.

[8] Uniting for Youth. (2009). King County Resource Guide: Information Sharing, Second Edition. Seattle, WA: Casey Family Programs. Retrieved from http://www.k12.wa.us/SafetyCenter/Gangs/pubdocs/KingCoResourceGuideInformationSharing.pdf; Arizona Juvenile Justice Commission. (2008). State of Arizona Systems Integration Initiative: Information Sharing Guide. Phoenix, AZ. Retrieved from http://www.ncjfcj.org/sites/default/files/AZ%20Info%20Sharing.pdf

4. Efforts need to be made to identify and treat children with mental health issues before they reach the juvenile justice system.

Law enforcement, schools, medical providers, and juvenile departments should adopt a uniform screening tool for at risk youth to identify the need for crisis services and the need for further mental health assessment. Recognizing that best practices may dictate the most appropriate screening tool change over time, the task force does not recommend mandating a particular screening tool be used. Rather, this issue should be referred to the Children's Cabinet for discussion and selection of the most appropriate tool, with the following principles in mind:

- The screening tool should be validated for the populations served, to take into account differences in race, ethnicity, age and gender.
- Systems should be established to allow for the sharing of the completed screen between schools, law enforcement, mental health, and juvenile justice.

The task force also recommends that when mental health problems are identified, systems respond to address the issue before more serious and costly problems develop. The OYA through the Oregon Criminal Justice Feeder System Project is working on ways to identify higher-risk individuals before they become involved with OYA or the Oregon Department of Corrections. Researchers are analyzing data to determine which systems youth interface with prior to entering the juvenile justice system. The idea is to figure out how to strategically allocate resources to provide services to those who need them earlier, and prevent more costly juvenile and criminal justice interventions later. Preliminary findings suggest participation in drug and alcohol treatment, mental health treatment and involvement in the child welfare system have the strongest correlations with future OYA involvement. In addition, Hispanic and Latino youth appear to have unequal access to community mental health treatment services. The task force endorses OYA's approach to help identify earlier possible points of intervention. In addition, the task force reviewed several other promising new approaches to identify and treat mental health problems before they result in juvenile justice involvement**,** as described below.

- <u>School Based Mental Health Care Coordination</u>

Three school districts in Oregon have school based mental health care coordination services available to youth and their families. Students and their families may be offered services based on truancy, behavior issues or symptoms of mental illness. After an assessment, care coordinators are available to meet with families at school, in their homes, or in the community, and are available to assist with accessing mental health services, medical services and basic needs. Preliminary evaluation of program outcomes indicates that children who participate in

these programs demonstrate a decrease in disciplinary referrals, a reduction in suspensions, improvement in grades, and decreased absenteeism.[9]

- Oregon Pediatric Society START Program

The Oregon Pediatric Society has offered training to medical providers around the state on standardized health screening to identify problems early and link families to appropriate services. The screening includes the detection and management of developmental delays, autism spectrum disorders, peripartum mood disorders, adolescent depression and substance abuse, and adverse childhood experiences.

- Marion County Sheriff's Office Mobile Crisis Unit

The Marion County Sheriff's Office has two crisis response teams that pair officers with mental health specialists to respond to individuals with chronic law enforcement contacts related to their mental health situation. The teams assist individuals to schedule medical appointments, obtain medication and secure housing to help them get stabilized. The program has resulted in fewer placements in jail and the Oregon State Hospital.

- Community Healing Initiative Early Intervention Diversion Program

The Multnomah County Juvenile Department is working with Gresham Police to connect low level first time juvenile offenders and their families with culturally responsive services in lieu of issuing a warning letter. This program provides at risk youth and their families the opportunity to engage in services designed to prevent the youth's entry into the juvenile justice system.

The task force recommends that innovative programs that identify and address problems early be evaluated to determine their effectiveness. If they are determined to be effective at stopping the progression of a child to eventual juvenile justice involvement, funding should be leveraged accordingly.

5. Youth who are referred to the juvenile department should be screened for mental health issues and connected with appropriate services if needed.

Juvenile departments should screen all youth placed in detention if a recent screen has not been conducted.[10] Screening should take place within 24 hours from when the youth is taken into custody.

[9] Baker, A., Case, R., & Salkield, S. (2014). A School-Wide System of Early Identification and Intervention for Students with Mental Health Needs. [Presentation]. *Making Connections: Promoting Mental Wellness and Reducing Adverse Childhood Experiences Conference.* Eugene, OR.

This recommended timeline should not restrict the juvenile department's ability to secure immediate crisis treatment for a youth through a hospital emergency department or other crisis service. Juvenile departments are encouraged to screen any youth who is referred to the juvenile department, regardless of whether they are detained, as local resources allow. A date should be established by which time all juvenile departments should have screening procedures in place for detained youth.

If a screening indicates a youth is in need of a mental health assessment, procedures should be established in each county to ensure timely access to that assessment. The mental health assessment should be completed within 48 hours, however, the procedure outlined in the next paragraph should be followed if the youth is in crisis. If a juvenile department is not able to comply within this time frame, this issue should be reported to the juvenile court and documented in the Juvenile Justice Information System. This data should be collected for purposes of determining whether there are adequate mental health services available for juvenile justice youth in each community. These recommended timelines should not restrict the juvenile department's ability to secure immediate crisis treatment for a youth through a hospital emergency department or other crisis service.

For youth who are in crisis, every juvenile department should have access to a regional assessment process or center that provides a holistic review of the youth and determine an appropriate level of care. The assessment should include evaluation of the youth's mental and physical health, and take into consideration the educational needs of the youth. The assessment should include a determination of whether the child can be maintained at home with intensive services or whether out of home placement is necessary. Child serving residential treatment providers should be convened to come to agreement on a uniform assessment that will meet their criteria for determining admission, and protocols for completing the assessment to avoid unnecessary delays. Youth in crisis should be placed in the least restrictive environment available, preferably in a therapeutic setting. Youth in crisis are not appropriate for detention centers, which are poorly equipped to provide the trauma informed crisis services needed by this population.

This assessment process should be available to all children, regardless of what system they are in or may be headed for. The child should have access to a temporary, trauma informed place to stay and stabilize, until the assessment process can be completed. This pause in processing of juvenile justice youth is particularly important to allow time to assess and determine what the child and family need, and prevent the filing of a juvenile delinquency petition based on a youth's placement in detention, which can pull the youth deeper into the system. Appropriate treatment decisions should be made based on what the child needs, and not necessarily be driven by what system the child is in.

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[10] Twenty four states require the administration of a standardized mental health screening tool during intake process for youth placed in detention. Wachter, Andrew. (2015). Mental Health Screening in Juvenile Justice. Pittsburg, PA: National Center for Juvenile Justice.

When an assessment recommends a treatment plan or a certain level of care, local procedures need to be put in place to ensure timely access to the recommended services. If youth are not receiving access to recommended services, the juvenile department should take steps to identify the barriers to accessing needed services and work collaboratively with the juvenile court judge, county commissioners, Coordinated Care Organizations, the mental health community and local leaders to find appropriate solutions. If additional state resources are needed, legislative representatives for the affected district should be contacted. Finally, when a local group identifies barriers or gaps in service, this information should be provided to the Oregon Health Authority (OHA). At the time of this report, OHA is engaged in a mental health service mapping project for the State of Oregon, to identify areas where available publicly funded services are not sufficient to meet demand. Dialogue with local leaders will provide a regular feedback loop when service deficiencies are identified at the local level.

6. Juvenile departments, mental health and Coordinated Care Organizations should work together to ensure interventions that youth are referred to are producing positive outcomes.

Juvenile judges are concerned about the availability of evidence based mental health programs within their judicial districts. The task force recommends juvenile departments and entities responsible for providing mental health services to youth at the local level work together to ensure services youth are referred to are producing positive outcomes. Juvenile department directors and judges should periodically discuss which programs are available, and the research that supports their effectiveness.[11] If gaps exist, community partners local leaders, and state representatives should be convened to identify solutions.

7. Additional legal protections regulating the use of psychotropic medications for youth involved in the juvenile justice system should be enacted to ensure children receive the same level of protection, regardless of which system they are involved in.

The task force conducted a review of the legal protections that exist for children placed in the following settings: (1) DHS substitute care, (2) juvenile detention, (3) OYA close custody, and (4) OYA substitute care, and found that different rules apply to youth depending on which agency provides supervision and whether the child is placed in close custody or substitute care. Since all of these children are in state care, the task force recommends that they be provided the same level of protection, regardless of where they are placed.

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[11] Lipsey, M., Howell, J., Kelly, M., Chapman, G., & Carver, D. (2010). Improving the Effectiveness of Juvenile Justice Programs: A New Perspective on Evidence-Based Practice. Washington, DC: Center for Juvenile Justice Reform, Georgetown University, provides a helpful framework for analyzing programs at http://cjjr.georgetown.edu/wp-content/uploads/2015/03/ImprovingEffectiveness_ December2010.pdf

Specifically:

- The protections provided in ORS 418.517 should be extended to youth placed in substitute care, secure facilities, and residential placements pursuant to the provisions in ORS Chapter 419C.

In addition, the task force recommends that additional protections be provided to all children placed in out of home care after child welfare or juvenile justice involvement, to ensure continuity in psychotropic medication management as the child moves between placements and systems.

- The following additional requirements should also apply to children placed in out of home care under the provisions of ORS 418.312 (DHS Voluntary Placements) and ORS Chapters 419B and 419C.

    - For purposes of this section, "supervising entity" includes the Department of Human Services, the Oregon Youth Authority, a juvenile department or an entity appointed by the court to provide supervision, treatment and care for the youth under ORS 419C.529 (Psychiatric Security Review Board cases).

    - When a child is placed out of home, the supervising entity should determine whether or not the child is taking any prescribed medications on or before the day the child is placed, and ensure those medications are continued while the child is placed out of home. The supervising entity should have procedures in place to verify the prescriptions, including checking the prescription bottle and contacting the prescriber if necessary. If the child or the child's parents/guardians don't provide a sufficient supply of medication, the supervising entity should have procedures in place to ensure that replacement medications are obtained and provided to the child as prescribed. The supervising entity shall not substitute prescribed medication with comparable medication without the consent of the child's current prescriber.

    - If a child is placed out of home and the supervising entity determines the child is taking psychotropic medications at the time of entering care and a mental health assessment has not been completed within the last three months, the supervising entity shall contact the current treating prescriber to determine whether a new mental health assessment is necessary. A new mental health assessment shall be required if the child's prescriber must change due to the new placement.

    - Supervising entities should have procedures in place to address situations in which a child needs to have medications re-evaluated based on current symptoms or side effects from the medication. If any medication is discontinued, changed, or if not being taken by the child as prescribed, the supervising entity shall notify the parent or guardian, and the child's attorney, within 24 hours.

- Supervising entities should have procedures in place to notify the parent or guardian of the current prescription for medication at the time of release from out of home care. The supervising entity should ensure the child leaves care with a 30-day supply of the current medication to last until a new prescription can be obtained or refilled. The supervising entity should work with the parent and/or youth to ensure health insurance coverage is available at the time of release, and the child has an appointment with the prescriber if needed to continue the medication.

- The following prescribing flags should trigger an independent review of the child's medications:

    - Poly pharmacy greater than 4
    - Two or more medications in the same class
    - Antipsychotic prescribing without metabolic monitoring
    - Medication for children under six other than stimulants
    - Antipsychotics
        - Child is under six
        - Multiple are prescribed
        - Longer than 6 months without a diagnosis

    - Any supervising entity that contracts with outside facilities for detention, shelter care or residential care services shall ensure the procedures outlined above and in ORS 418.517 are in place in those facilities prior to placement.

8. Youth who cannot be safely maintained at home with serious mental health needs should be placed in the least restrictive available trauma informed treatment setting.

The task force recommends that youth with significant mental health needs be placed in settings other than secure confinement or the hospital. When public safety allows, the first option should be to try and deliver services to the youth and family at home. For youth in crisis who can't be maintained at home, more options need to be developed. Jackson County recently implemented a foster care respite home to provide a safe alternative to detention. The foster home provides a temporary place for a youth to stabilize while a more permanent solution can be found. Having more such options available throughout the state would relieve some pressure on detention centers and hospitals.

In addition, the system for accessing treatment beds should be reformed. The task force heard from juvenile department directors, judges, attorneys, and OYA staff that the system for accessing these programs is broken. There is currently no way to track how many beds are available statewide, how many are filled, and how many youth are denied services because they do not meet admission criteria. This leads to agencies submitting multiple applications to various programs, increased administrative delays and deterioration of youth who are waiting in inappropriate placements for care. The task force recommends exploration of a central statewide clearinghouse through which applications would be

submitted, available placements would be monitored, waiting children would be tracked, and denials of service would be documented. The clearinghouse should include all available beds, regardless of funding stream, focused on higher levels of care such as multi-dimensional treatment foster care, residential care, behavioral rehabilitation services, and psychiatric placements. The task force believes this issue deserves immediate attention.

Youth who cannot be safely maintained at home with services should be placed in the least restrictive available out of home placement. Current research on evidence based interventions for delinquent youth who must be placed out of home supports the use of Multidimensional Treatment Foster Care (MTFC) over residential placements.[12] The American Academy of Child and Adolescent Psychiatry has identified this model as a cost effective alternative to hospitalization and secure confinement for youth with chronic antisocial behavior, emotional disturbance and delinquency.[13] The MTFC model is in use in Oregon, however, questions have been raised as to whether adequate resources have been dedicated to MTFC programs. The task force recommends further evaluation to determine if a sufficient number of MTFC placements exist to meet demand, and whether adequate supports are being provided to foster parents to maintain children in their care and prevent further delinquency.

In addition, the task force recommends a comprehensive review of the residential care system in Oregon be conducted to determine whether youth who need services are able to access them, and whether those youth who are placed in residential care are experiencing positive outcomes. Research regarding the following questions should guide the provision of services for system involved youth in Oregon:

- Are out of home placements that provide a higher level of care than regular foster care for juvenile justice and child welfare youth producing positive outcomes? [14]
- Are the right assessment tools being used to match youth with the appropriate programs, and are the people using them well trained?

[12] Gilliam, K., Fisher, P. (2012). Multidimensional Treatment Foster Care: An Alternative to Residential Treatment for High Risk Children and Adolescents. Madrid, Spain: *Psychosocial Intervention*, (21) 195-203.

[13] American Academy of Child and Adolescent Psychiatry. (2013). Systems-Based Practice Juvenile Justice System. Retrieved from https://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/training_toolkit_for_systems_based_practice/Systems_Based_Practice_Module_Juvenile_Justice_201406.pdf (last visited November 10, 2015)

[14] Preliminary findings from the OYA Feeder Project indicate children who have been in residential care are more likely to have subsequent juvenile justice involvement. Oral report from Margaret Braun, Ph D, November 20, 2015.

- Can some youth who are currently being placed in residential care be served in less restrictive settings, such as MTFC or at home, if appropriate services and supports are made available?
- Excluding youth who could be served in a less restrictive setting with additional supports, is there still a deficit in the number of residential treatment beds?
- What data exists to determine: (1) how many youth are being denied placements; (2) the reason(s) for the denial; and (3) the alternative care being provided to these youth and its effectiveness.
- Are youth with behavioral health conditions or 'borderline' intellectual or functional disabilities who exhibit violent aggression, or who have a history of assault, property destruction, or sex offenses being systemically excluded from out of home treatment beds?
- What is an appropriate setting for extremely aggressive youth and what interventions are effective?
- Is there a need for a new treatment facility in Oregon that serves youth who currently don't fit within existing systems?

The task force recommends these questions first be referred to the Oregon Health Authority's mapping technical advisory committee for consideration. Any questions that cannot be resolved by this group should be subject to further professional evaluation to ensure tax dollars are being leveraged appropriately.

Finally, time limited out of home placements may not support long term delinquency prevention goals. Task force members expressed concern that in many cases, once a youth is stabilized, the youth is moved to a different, less restrictive placement based on rules that restrict the youth from remaining in the placement. These transitions are sometimes made without adequate transition and supportive community services in place. Transitions may also be necessary when youth move between delinquency and dependency systems. The change in placement can be disruptive to the youth's recovery, leading to a cycle of temporary stabilization, deterioration at the time of placement change, and re-entry into the system. The task force recommends adequate transition planning and supports be put in place before youth are transitioned from residential or other out of home placements. This requirement can be mandated and monitored through licensing of Oregon residential and BRS treatment providers in Oregon and through governmental agencies who are responsible for supervision of these youth, such as the Department of Human Services, Oregon Youth Authority and local juvenile departments.

9. Juvenile departments and the Oregon Youth Authority should ensure that youth have adequate mental health services set up in the community when youth are released from custody. Coordinated Care Organizations (CCOs) should be mandated to schedule appointments with these youth prior to their release from custody to ensure adequate supports are in place when the youth returns to the community.

The task force recommends that youth who are incarcerated in juvenile detention or through OYA have mental health and other supportive services established in the community prior to release. Adequate coordination and transition planning will ensure continuity in psychotropic medication management, mental health services, and other family supports, and is necessary to support the youth's placement in home.

In Oregon, CCOs should be required to work with juvenile justice agencies to coordinate care for incarcerated youth when youth are close to being released. Federal Medicaid restrictions prevent incarcerated youth from enrolling in the Oregon Health Plan while they are incarcerated. CCOs in Oregon are unwilling to schedule medical and mental health appointments for youth until they have insurance. Consequently, youth are not enrolled in insurance until the day of release or later. This dynamic, combined with an inadequate supply of mental health and medication management services in some areas of the state, puts youth at risk for delays in receiving services.

The task force recommends that the Oregon Health Authority (OHA) require CCOs to work with juvenile justice agencies in Oregon to ensure continuity of care. This includes scheduling medical appointments prior to the youth's release date and prior to enrollment in health insurance. The specific requirements should be set forth in the next contracting cycle, which is not expected to take place until 2018. The OHA should encourage CCOs to change their practices prior to that time to reduce costs associated with delays in receiving care.

The task force did not discuss the needs of youth or young adults who are not within the CCO system. This includes uninsured youth and youth with private insurance. Further discussion needs to occur to determine whether systems reform is necessary to ensure appropriate transitions are being made by this population to the community upon release.

Juvenile Justice Mental Health Task Force Survey of Juvenile Departments
Summary Results
October 2, 2015

There are a total of 36 counties included in the responses below.

SCREENING AND ASSESSMENT

Does your juvenile department provide any mental health screening when youth enter the system?

YES	13	37%
NO	23	64%

If yes, what screening tool is used?

MAYSI	5	38%
GAIN	1	8%
OTHER	6	46%

Responses provided under "Other":

- JCP **(2 responses)**
- Drug and alcohol assessments and/or mental health assessments if indicated
- Suicide assessment to determine risk and level of supervision at detention facility; crisis mental health is contacted if the youth scores over a certain criteria
- JJIS risk assessment has mental health elements within it
- CASI II Detention Mental Health Screening tool

If yes, who conducts the screening (multiple responses accepted)?

Juvenile Department Staff	11	85%
Mental Health Professional	5	38%
Other	1	8%

Responses provided under "Other":

- Intake worker (juvenile department), Nurse (county health department), Mental health consultant (juvenile department)

If yes, at what stage is screening completed (multiple responses accepted)?

If Youth Placed in Detention	9	69%
At Time of Referral	4	31%
Other	6	46%

Responses provided under "Other":

- Upon intake **(4 responses)**
- ACEs for youth being placed on Probation
- JCCs ask about mental health as part of the social history information gathering meeting with a youth and parent/guardian

If no, is there some other process available to identify youth with mental health problems (multiple responses accepted)?

Observation by Staff	19	83%
Information from Parents	18	78%
Mental Health Records	13	57%
Other	15	68%

Responses provided under "Other":

- Referral to mental health provider **(5 responses)**
- JCP Assessment **(3 responses)**
- School reports **(3 responses)**
- Police reports **(2 responses)**
- The crime that was committed
- JJIS assessment has a domain for mental health

Do youth in your system get referred for a mental health assessment?

Benton had conflicting responses, all other counties included.

YES	34	97%
NO	1	3%

If not, what are the barriers to providing assessments?

- No barrier- they can refer anyone

If yes, who makes the referral (multiple responses accepted)?

Juvenile Department Staff	34	100%
Mental Health Provider	11	32%
Other	4	12%

Responses provided under "Other":

- Court **(2 responses)**
- Harkins House shelter, parents, school
- Defense attorney

If yes, who does the assessment (multiple responses accepted)?

County Mental Health	26	76%
Outside Contracted Provider	19	56%
Juvenile Department Staff	5	15%
Other	12	35%

Responses provided under "Other":

- Private non-profit mental health provider that contracts with the county **(4 responses)**
- Private mental health provider **(4 responses)**
- Community based providers (not contracted) **(3 responses)**
- Graduate student mental health interns
- Insurance or OHP contracted provider

If yes, how do you know to refer the youth (multiple responses accepted)?

Behavior	33	97%
Screening Instrument	16	49%
Other	18	53%

Responses provided under "Other":

- Consultation with others- parents, school, youth's attorney, mental health provider **(10 responses)**
- Background info gained during intake process **(3 responses)**
- Conferring with mental health provider **(2 responses)**
- JCP Assessment **(2 responses)**
- Nature of the crime **(3 responses)**

Who pays for the assessment (multiple responses accepted)?

Youth's Health Insurance	34	100%
Juvenile Department	26	76%
Parent	25	74%
County	8	24%
Other	11	32%

Responses provided under "Other":

- OHP **(5 responses)**
- Interns are free
- Sometimes diversion dollars
- DHS
- Varies depending on need
- Pass through funding from OYA and Youth Development Counsel- most youth are OHP eligible
- Provider will bill insurance if available, but otherwise is covered by a contract between the Juvenile Dept and mental health/Occasionally the Juvenile Department

RECORDS

Which records would help you determine appropriate responses and services when a youth is referred to the juvenile department (multiple responses accepted)?

School	36	100%
Mental Health/DD	36	100%
Child Welfare	36	100%
Law Enforcement	35	97%
Medical	30	83%
Other	7	20%

Responses provided under "Other":

- JJIS **(3 responses)**
- Parent's criminal history, mental health, D&A history
- Prior evaluations/prior placements outside of the home
- Any and all information may be helpful- limiting information prior to intake is silly
- Assessments completed as part of an intake process; if high enough risk additional assessments that can assist in typology and the Youth Reformation System

Which records do you ask for when a youth <u>is placed in detention</u> or <u>is being considered for placement in detention</u> (multiple responses accepted)?

Law Enforcement	32	89%
School	17	47%
Mental Health/DD	17	47%
Child Welfare	17	47%
Medical	11	31%
Other	6	17%

Responses provided under "Other":

- We do not regularly ask for all of the above after a detention placement or prior to making a detention decision; it is often a case by case process **(2 responses)**
- Medication information
- Probation officers will gather the remaining records as youth are referred or placed in detention
- Normally already have law enforcement information on youth through JJIS. Normally are denied mental health and child welfare records even when they have been working with the youth for years
- Depends if it is a new law violation or probation violation

Do you ever have trouble accessing needed information about the youth?
Umatilla did not respond to this question.

YES	19	54%
NO	16	46%

If yes, please explain:

- Lack of info available **(4 responses)**
- People not always forthcoming about historical information **(4 responses)**
- Difficulty getting needed releases signed and finding appropriate holder of the information **(5 responses)**
- Time delay in receiving records **(3 responses)**
- Youth's attorney will not allow releases of information to be signed **(2 responses)**
- Sometimes we may be stuck on what to do with a youth

If a youth is placed in OYA custody, which juvenile department records are provided to OYA upon transfer (multiple responses accepted)?

Education	36	100%
Offense History	36	100%
Mental Health	35	97%
Assessments/Evaluations	35	97%
Medical	32	89%
Other	10	28%

Responses provided under "Other":

- JJIS records **(4 responses)**
- Reformation plan **(3 responses)**
- Court reports (including social history), legal history/documents **(2 responses)**
- Family history

HEALTH INSURANCE

Is there a check completed to see if a youth has health insurance?

YES	32	89%
NO	1	3%
UNKNOWN	3	8%

If yes, at what stage (multiple responses accepted)?

At Time of Referral	22	69%
If Youth is Placed in Detention	9	28%
Other	12	38%

Responses provided under "Other":

- During intake process **(11 responses)**
- If medical, medication, or mental health issues arise

If yes, who conducts the check (multiple responses accepted)?

Juvenile Department Staff	30	94%
Other	5	16%

Responses provided under "Other":

- Local Mental Health/County Mental Health/Mental Health staff **(5 responses)**
- DHS

If yes, what is done if the youth has no health insurance (multiple responses accepted)?

Assistance is Provided to Sign Up	24	71%
Nothing	3	9%
Other	4	12%

Responses provided under "Other":

- Sliding scale fee by county mental health
- Indigent defense fund, Marion County Juvenile Dept contracted on-site nurse (in detention), and mental health providers
- Family is contacted
- We pay for assessments

PSYCHOTROPIC MEDICATION

Is there a check completed to see if the youth is taking or is prescribed psychotropic medication, or other supplements that may affect mood?

YES	33	92%
NO	2	6%
UNKNOWN	1	3%

If yes, who completes the check (multiple responses accepted)?

Juvenile Department Staff	33	100%
Mental Health Professional	12	36%
On Site Medical Personnel	11	33%
Other	8	24%

Responses provided under "Other":

- Detention staff- either upon intake or during monitoring **(5 responses)**

- If mental health issues are prominent or if the screening tool identifies a follow-up; otherwise, I may not inquire as to the psychotropic drug issue
- Reported by youth or parent
- Self-reported (by family) in addition to mental health provider

If yes, how is the check completed (multiple responses accepted)?

Ask Youth	33	100%
Ask Parent	33	100%
Medical Records	13	39%
Check with Prescriber	13	39%
Other	5	15%

Responses provided under "Other":

- Check with counselor if youth is working with one; check with school staff
- Ongoing medical rounds meeting also draws on info from until behavior reports, sleep logs, diet and school reports
- Ask mental health provider
- Depending on how much info they are willing to give; often we are left to self-report which is not always the most accurate, but if we can manage to get ROI's and get further into the system, direct contact with providers, medical records etc...is always preferred
- Info from referring agency

If yes, when is the check completed (multiple responses accepted)?

At Referral	24	73%
When Placed in Detention	20	61%
Other	10	30%

Responses provided under "Other":

- Intake process **(7 responses)**
- If suspected
- When placed in detention
- Daily monitoring protocols and formal weekly rounds

Are psychotropic medications continued while the youth <u>is in detention</u>?

YES	36	100%
NO	0	0%

If no, please explain (5 counties gave explanations even though they answered "yes")
N/A

If yes, who administers the medication (multiple responses accepted)?

On Site Medical Personnel	22	61%
Juvenile Department Staff	8	22%
Other	10	28%

Responses provided under "Other":

- Detention staff **(6 responses)**
- Unknown- detention center is located out of county **(2 responses)**
- Nursing staff **(2 responses)**

What protocols are in place to monitor the youth for side effects (multiple responses accepted)?

Staff Observation	21	58%
On Site Medical Personnel	18	50%
Log	17	47%
Staff Talks to Youth About How They Are Feeling	15	42%
Periodic Counseling Sessions	9	25%
Other	11	31%

Responses provided under "Other":

- Unknown- detention is not onsite/in county **(9 responses)**
- Detention has rules/protocols around this **(2 responses)**
- Education staff also monitors youth in custody

Are changes ever made to psychotropic medications while a youth is in detention?

YES	21	57%
NO	7	19%
NOT ANSWERED	8	22%

If yes, what is your protocol for achieving this? Do you ever have problems getting a new prescription, and if so, what are they?

- If ordered by a prescriber/doctor/mental health- either on site or when youth is transported to medication management appointments **(11 responses)**

- Rarely done **(3 responses)**
- Unknown **(2 responses)**
- Youth can be released to parent/juvenile counselor for transport to psychiatrist's office for med appointment and then returned to detention.
- As needed by detention staff per protocol

If side effects are noted, what is done (multiple responses accepted)?

Notice to On Site Medical Personnel	19	53%
Mental health Assessment or Medication Management Review is Conducted	14	39%
Notice to Parents	11	31%
Appointment is Made with Prescriber	10	28%
Notice to Child's Attorney	4	11%
Other	10	28%

Responses provided under "Other":

- Unknown/ We don't have our own detention facility **(7 responses)**
- Youth might be transported to medical appointment for review
- Probation officer is notified
- Rely on detention staff

Are any arrangements made to continue the youth's medication upon release from detention (multiple responses accepted)?

Steps are Taken to Reinstate Youth's OHP	15	42%
Juvenile Department Obtains Supply for Youth	11	31%
Appointment is Made with Prescriber	10	28%
No	1	3%
Other	11	31%

Responses provided under "Other":

- Youth leaves detention with medication/medication is released to youth & family **(5 responses)**
- Information passed on to parents/next placement **(4 responses)**
- Comply with medical recommendations per court order

- Depends of the length of stay and where they go upon release- a youth going home may be different than a youth going to OYA custody or a mental health placement
- Varies- Corrections Health provides a small supply for youth upon discharge, JCC may assist in linking to community provider, or this may be done by another professional or the parent

Does the juvenile department have any involvement in ensuring continuity in psychotropic medication management if the youth is placed in care pursuant to a Formal Accountability Agreement, or Voluntary Placement Agreement?

YES	17	47%
NO	19	53%

If yes, please explain:

- Work with family to ensure youth has his/her medications if placed out of home on a VPA **(4 responses)**
- We will make taking prescribed medications a part of a FAA but we do not place youth in care pursuant to FAA's **(2 responses)**
- Through conversations with placement authority and placement providers
- We handle it the same way as if it were a formal case
- Juvenile staff ensure that the medication is given to a parent or guardian
- At times as part of a referral to mental health services
- We participate as part of case planning
- We work with family to assure that program knows meds are needed
- Perhaps- we would attempt to always maintain a continuity of service regardless as to whether they are on Formal Probation or an FAA
- If youth is in imminent risk of entering into the juvenile justice system

CRISIS SERVICES

For youth who are referred to the juvenile department (or who are in detention) and are in crisis, what options do you have available (multiple responses accepted)?

Emergency Mental Health Assessment	31	86%
Crisis Counseling	31	86%
Emergency Room	30	83%
Special Emergency Foster Care Placement	10	28%
Emergency Residential Placement	8	22%

Other	9	25%

Responses provided under "Other":

- Crisis counseling/assessments done by county mental health agency **(3 responses)**
- Detention has been used in crisis situations **(3 responses)**
- On site mental health providers are available
- Washington County crisis team; police agency
- Youth investment coordinator

For youth in crisis, <u>what options do you need that aren't available</u> in your community (multiple responses accepted)?

Special Emergency Foster Care Placement	22	61%
Emergency Residential Placement	22	61%
Emergency Mental Health Assessment	6	17%
Crisis Counseling	5	14%
Emergency Room	1	3%
Other	7	19%

Responses provided under "Other":

- Faster response time by our local provider- and maybe a more thorough evaluation- they are hit and miss depending on the provider; more foster beds are needed
- Medication management with a psychiatrist is typically a couple of months wait; youth without insurance can take weeks (and weeks) to get OHP so we can begin regular services.
- Accessible inpatient psychiatric treatment
- Respite care
- Emergency shelter care
- Juvenile Response Team
- More options
- We can always use more emergency placements for youth in crisis.

Do you believe that detention stays could be reduced if alternative placements were available in your community for youth with mental health issues?

Clatsop didn't respond.

YES	30	83%
NO	4	11%

NO RESPONSE	2	6%

MENTAL HEALTH SERVICES

Clatsop didn't respond to this section.

Are mental health services available to youth who are referred to the juvenile department?

YES	35	97%
NO	0	0%
NO RESPONSE	1	3%

If no, please explain.
N/A

If yes, how are those services provided (multiple responses accepted)?

County Mental Health	29	83%
Contracted Outside Providers	20	57%
Juvenile Department Staff	8	23%
Other	5	14%

Responses provided under "Other":

- Private providers contracted through county mental health and provided through youth's private insurance
- Contracted provider housed at building
- CCS is private non-profit and not county anymore
- Community mental health providers (not contracted)
- Community mental health providers, graduate school mental health interns

Are mental health services available to youth who are placed in detention?

YES	33	94%
NO	2	6%

If no, please explain:

- Detention facility has a nurse on site but mental health services are not provided
- Unknown

If yes, how are those services provided (multiple responses accepted)?

County Mental Health	20	57%
Contracted Outside Providers	16	46%
Juvenile Department Staff	8	23%
Other	10	29%

Responses provided under "Other":

- Detention center has on site mental health/medical services **(4 responses)**
- Unknown- detention facility not local **(3 responses)**
- Contract with other county mental health department
- County health department (Corrections Health), Community providers (not contracted)

Are mental health services continued after the youth is released from detention?

YES	32	92%
NO	3	9%

If not, why not?

- Not with the mental health providers at detention; they are only accessed while in detention **(2 responses)**
- Inconsistent dependent on parent follow through and barriers such as expense, transportation to appointments, and matching youth to providers

With the same provider?

YES	16	50%
NO	17	52%
NO RESPONSE	2	6%

If not, why not?

- No detention center in county/ Youth in detention received services from the county in which the facility is located; when youth is returned home, local resources are used **(13 responses)**
- Mental health counselors in detention do not meet with any youth outside of detention **(3 responses)**
- Depends on the youth's living situation. If they were sent to detention because they were terminated from a program, said services would be transferred to a provider at/near their new placement

What services are available (multiple responses accepted)?

Service	Community	Detention
Cognitive Behavioral Therapy	31	16
Medication Therapies	31	13
Dual Diagnosis Treatment	31	4
Dialectical Behavioral Therapy	23	1
Functional Family Therapy	19	4
Aggression replacement Therapy	19	6
Multi-systemic Therapy	15	3
Multi-dimensional treatment for Foster Care	9	2
Other	5	

Responses provided under "Other":

- Trauma treatment; substance abuse treatment
- ART available in detention for 30 day program youth
- Individual family therapy; Brief strategic family therapy; Dual-diagnosis through Bridgeway only DBT in our GAP shelter facility
- Multi-Dimensional Family Therapy Wraparound
- SRT (Social Recondition Therapy)

How do you know mental health and other treatment services you refer youth to are effective (multiple responses accepted)?

Evidence-based Programs	25	69%
Periodic Evaluation	11	31%
Other	14	39%

Responses provided under "Other":

- Youth and parent report **(3 responses)**
- Youth's involvement in the program and behavioral changes **(4 responses)**
- Many times we have to exhaust all options before youth are accepted into a program that we wanted to access in the first place. So, a youth may have several different attempts at outpatient services and residential placements before getting into a program that best fits their needs.
- Program coordination and monitoring of youth progress towards service goals

- We have no formal method but will only refer to providers who practice from CBT perspective and those who we have worked with in the past
- We don't/ not sure services are effective due to limited services
- We do track and evaluate, but there is only one provider in Tillamook County that the Juvenile Department has available to refer youth to for mental health services
- We are a small rural county - we attempt to implement evidence-based programming, but there are limitations. Evaluations are not scientific, but we do some comparisons and keep data.

If evidence-based programs are chosen, how do you determine this?

- Allow the provider to determine/ We have one provider and depend on them to provide EBP services **(4 responses)**
- Research proven **(3 responses)**
- SAMSHA **(2 responses)**
- CPC
- We refer to the OJJDP list of outcomes based programs and monitor grant funding opportunities
- If they meet the criteria of evidence-based services
- We ask for evidence of evidence based programs. We discuss this with providers.
- From National research clearing house.
- We are knowledgeable about the programs offered in our community.
- Case by case basis

Periodic Evaluation. Explain:

- We review progress with the providers on a regular basis **(5 responses)**
- Monthly staff meetings/on-going staffing **(3 responses)**
- We track recidivism and programmatic outcomes **(2 responses)**

If no services are provided, what are the barriers to accessing services (multiple responses accepted)?

Not Enough Providers Available in Area	15	42%
Wait Times to See Provider Are Too Long for Youth	9	25%
Providers Not Willing to Treat Youth	5	14%
Juvenile Department Staff Not Trained to Connect Youth to Services	2	6%
Other	9	25%

Responses provided under "Other":

- Lack of insurance/inability to pay for services not covered by insurance **(3 responses)**
- Uncooperative youth and families **(3 responses)**

- Not enough child psychiatrists; DBT has HUGE wait times and then is very expensive. Limited trauma treatment services.
- Language barriers
- Many times we have to exhaust all options before youth are accepted into a program that we wanted to access in the first place. So, a youth may have several different attempts at outpatient services and residential placements before getting into a program that best fits their needs.

In your opinion, are there specific types of mental health services that are difficult to access?

Residential care	31	86%
Emergency placements	28	78%
Psychiatric evaluations/consultation	18	50%
Home-based support	18	50%
Prescriber/medication management services	18	50%
Trauma informed treatment protocols or strategies	14	39%
School based support	12	33%
Clinic based treatment services	5	14%
OHP providers	5	14%
Mental health assessment	3	9%
Other	4	11%

Responses provided under "Other":

- DBT Virtually all mental health services for youth with Kaiser or other private insurance
- In general, there is a lack of provider who are skilled in working with youth in juvenile justice system. Services that are provided are difficult to access (slow)
- Intensive services to prevent crisis or emergency responses
- Family therapy

What do you think the barriers are to these services?

- Lack of providers/services available in county **(12 responses)**
- Funding/Cost of programs/lack of local financial resources **(8 responses)**
- Rural county- services not available in county or very limited **(8 responses)**
- Location and transportation **(2 responses)**
- Difficult to access language/culturally appropriate services **(2 responses)**

- DMAP disenrollments is a HUGE problem for youth in detention and when youth leave detention
- Mental Health stigma
- Lack of state-wide acute psychiatric services
- CCOs

Please describe any problems you have experienced finding an appropriate placement for youth who are not appropriate for detention, but who can't be maintained safely at home:

- Lack of available alternative placements/We have no other options than to hold them in detention **(8 responses)**
- No other placement resources available **(7 responses)**
- The higher risk kid in mental health is similar to the one in Juvenile Justice. They drain the system and often there are not adequate resources within the system to address their needs. Residential providers and emergency placements for juveniles are difficult to access or nonexistent. Long-term residential treatment beds are nearly non-existent, so MH youth go from crisis to crisis, to local EMU, to detention, to brief stabilization placements, back home, crisis…repeat. **(3 responses)**
- Lack of resources for mental health and DD youth- MH does not have the resources for placement of youth and therefore rely on the security of a detention program **(3 responses)**
- Significant issue for girls with child welfare histories who are at risk of running- no shelter or respite for these girls through DHS **(2 responses)**
- OYA does not have residential resources to work with youth with mental health issues. Furthermore, OYA does not believe that they should work with those youth. They believe youth with mental health issues should be treated by the mental health system, even when there are safety issues and the youth does not meet criteria for mental health residential.
- Frequently, our two (for the whole county) detention beds are occupied with youth that don't have an appropriate community placement. These are youth that have been identified as needing BRS placement, drug and alcohol treatment, and/or a psychiatric residential placement. It seems that when these youth are identified, the various programs feel that the youth more appropriate for one placement over another, when, in reality, many of these youth have co-occurring issues that can be addressed in any number of programs. The most common struggle seems to be this concept of not referring a youth to a particular type of program until other programs have denied them. This really slows the process and leaves youth in detention beds for an inappropriate amount of time. Additionally, when a youth is in detention, there seems to be a lack of urgency for other agencies (Mental Health or DHS) to find a more appropriate placement. It seems that other, less restrictive options that would be otherwise considered if detention was not an option for a particular youth, are not considered when the youth is in custody. Detention has become a type of secure shelter placement at times as a result.
- Funds for the length of time needed to effectively impact behaviors related to a life time of trauma. Community capacity to work with behaviorally difficult youth in supportive or shared living environments, Finding a clean, safe and sober home setting for youth to engage in IOP (AOD and/or MH svcs).

- We have no ability to pay for shelter options. Also have no ability to access foster/respite homes.
- A frequent issue is security and safety issues. The youth won't fit the levels of care that exists and the level of care needed for these youth for out of home placement don't exist. There is also a serious lack of parental/family support.
- Hospitals are very hesitant to admit a youth who is having a mental health crisis in detention because they are deemed to be "safe" and getting needs met in detention.
- I could write a book in here.

MISCELLANEOUS

Clatsop didn't respond to this section.

Has any data been collected in your county about the prevalence of youth with mental health issues who are referred to the juvenile department?

YES	5	14%
NO	30	86%

If yes, would you be willing to share it with the Juvenile Justice Mental Health Task Force?

YES	5	100%
NO	0	0%

In your opinion, do you get inappropriate referrals of youth or requests for juvenile department involvement when the primary problem is an underlying mental health issue?

YES	30	86%
NO	5	14%

If yes, from:

Law enforcement	29	85%
Schools	24	71%
Parents	22	65%
Child welfare	23	68%
Other	7	21%

Responses provided under "Other":

- Local mental health agency **(3 answers)**

- Residential treatment programs (filing police reports on youth with acting out behavior related to their mental health)
- We are often asked to perform detention "safety holds" on MH youth because our local EMU, after initial short-term stabilization, has no other place to put them.
- Yes, and no. Most of our referrals come from law enforcement. Often times the mental health side of the referral manifests itself at intake or later. Many of the kids who further penetrate our system have been in multiple other systems (self sufficiency, mental health, foster care, drug and alcohol)- Note OYA's recent feeder system work. Very telling data.
- All our referrals come from law enforcement. Many of our referrals do come from youth with mental health issues being placed in a residential or foster program by DHS, being charged with assault against a foster parent, residential staff or another student in the program and then all of a sudden they are delinquent not the responsibility of DHS anymore.

What system changes do you believe would improve our collective response to youth with mental health issues?

- The development of an assessment center, increased resources in mental health and DD, school based providers, and increased prevention **(8 responses)**
- More service options that are less restrictive than detention/not allowing the juvenile justice system to be the default for youth that have mental health issues and have committed a criminal act **(3 responses)**
- Better coordination between agencies/systems information sharing as well as developing protocols between agencies where families and youth receive appropriate, coordinated services **(3 responses)**
- The whole system should be addressed, it cannot be just the juvenile dept./ Don't get me started on DHS and the damage they do to already traumatized kids- the foster care system needs a complete overhaul. **(2 responses)**
- Respite/temporary safe placement **(2 responses)**
- Increased acute psychiatric services/residential treatment beds **(2 responses)**
- Focus on prevention and early intervention in early childhood; provide intensive community-based services sooner to reduce reliance on residential care **(2 responses)**
- Education to the school districts/ School staff needs more mandatory training on managing behaviors and recognizing mental health needs- instead of removing them from the school. **(2 responses)**
- More intensive in-home resources
- We need more people that specialize in the needs and challenges of kids and teenagers, and those people need to be passionate about that population. Then we need to support and compensate them appropriately so they stick around. A counselor who sees a youth as a little adult can do more harm than good. There should be more state/federal funding for shelters- we put a lot of work into a runaway and homeless youth grant and weren't funded. Kids need a safe place to receive services so they don't default to the juvenile system.
- The State of Oregon needs a comprehensive commitment to partner with communities to create new facilities, new residential treatment centers, and new shelter capacity. The de-

institutionalization movement only shifted the burden to local communities without resources, expertise, or the ability to deal with the problem. Thus, juvenile detention facilities and adult jails became the default placement of last resort. Instead, we need a systematic overhaul to create new treatment facilities capable of taking care of MH clients long-term as well as providing shorter-term treatment, stabilization, and care for those who can be safely transitioned back into community placement. And, we need MH authorities monitoring the progress of these transitioned clients.

- Strengthen laws to maintain detention for youth that are public safety risks, restrict findings of risk to self. Encourage schools and local mental health organizations to collaborate on continuity of care - school counselors alone are not sufficient. Increase education with all sectors on adolescent brain development and mental illnesses. Increase funding and expectations of providers around trauma-informed treatment and finally performance based contracting with providers.
- We have a lot of cogs in the system all working sometimes independently of one another. Although the Wrap around approach has shown some successes, it generally comes down to one or another agency taking on that lead role, which can make that whole approach problematic. In general, I've always believed early intervention (even earlier) is probably the best approach. By the time my 15 year old IV drug user hits my door, a lot of services have likely been offered and to varying degrees have failed him/her. We also need more resources for the adolescent offender. Using the same example as above, how many other resources have already given up on my 15 year old? I can tell you, many, if not most. And then it's, well now he or she is your problem (like we're the end game). Child welfare is probably the worst partner agency with respect to this issue.
- Systems need to serve youth, and not try to exclude youth and push them onto another system
- OYA needs to develop resources and philosophy to serve youth with mental health needs. The statistics on mental health youth in juvenile justice are well known, and they show that we have a significant percentage of youth with mental health issues we are working with. We can't keep saying, "This is a Mental Health (department) case," and then close the juvenile justice case. If the police are called, (often repeatedly), petitions are filed, the youth is adjudicated and put on probation, then it IS a juvenile justice case.
- Regardless of age, youth NEEDS should be the priority. A trauma-informed approach helps to identify a variety of issues a youth may be dealing with and addressing those needs on the front-end will help prevent further penetration into the criminal justice system. When allegations of abuse (victimization) are confirmed at an early age, rather than close the allegation because the "offender is out of the home" (for example), a case should be opened to help serve the needs of the youth. It simply cannot be left to the parent (who may have, knowingly or possibly due to lack of supervision, allowed said abuse to occur in the first place) to appropriately address the victimization needs. As we see time and time again, when left untreated, these kids continue to be put into situations where more abuse/trauma occurs. The layers of destruction grow thick and by the time these kids (victims) act out in school or in the community, folks assume they are 'out of control' with behavioral issues, oppositional defiance, conduct disorder, sex offending (rather than sexually reactive) etc. Perhaps if their needs were

met at a very young age when we had our first opportunity to intervene, we could prevent a long difficult path for some of these kids and families. Kids with trauma and mental health needs should not have to float through the system until they act out criminally. Far too often we hold kids in detention for weeks/month(s) due to no other placement being available. Many of them sit there on low level charges. The Oregon Youth Authority should be a last resort but too often we commit kids to OYA simply for their ability to find a residential placement. Shouldn't have to be that way. The NEEDS of the youth should come first...

- More education to law enforcement about youth and/family mental health and disabilities and how to work with them without increasing the issue. More funding available for evaluations and determination for aid and assist issues, and work on system of care for those youth determined to not be likely to change with restorative services. Continued training on trauma informed care, and the detrimental long term affects on youth, families, community safety when youth with mental disabilities are incarcerated to get services, instead of remaining in their communities and developing community supports for lifelong living, not just removing the problem until they are an adult.

Juvenile Justice Mental Health Task Force Survey of Juvenile Court Judges
Summary Results
November 5, 2015

1. In the last year, please estimate how many juvenile (delinquency or dependency) cases you've handled involving youth either in crisis or with mental health needs, who needed a crisis or residential placement that was not available within a reasonable time.

0	0	0%
1-3	13	43%
4-6	8	27%
7-10	4	13%
11-20	1	3%
More than 20	4	13%
	Responses Received:	*30*
	No Response Given:	*2*

2. In your opinion, what are the barriers for kids to be placed in appropriate crisis and mental health placements in your jurisdiction?

Not enough beds available	29	91%
Eligibility requirements too strict	13	41%
Process too cumbersome	10	31%
Inconsistent assessments required among providers	6	19%
Other (please specify)	6	19%
	Responses Received:	*32*
	No Response Given:	*0*

Responses provided under "Other":

- Children being denied placements because they are either too delinquent, or don't have severe enough issues
- There is no coordination about how to get mental health treatment. As a default we house kids in our detention facility because we can't access appropriate mental health services. Worse there seems to be no one accountable for this system.
- Secure treatment beds are not available (for both delinquent youth and chronic runaway DHS children)
- Possible insurance coverage issues
- Too far away and not enough money
- Too much time

3. Please clarify if you know what the requirements are that exclude kids:

Responses Received:	*9*
No Response Given:	*23*

- Violent/threatening behavior
- Inability to access nearby beds/resources in Idaho. Geography- long distance from treatment resources, no local crisis beds, no mental health holding facility in local hospital, lack of bed space generally.
- Primarily payment approval, lots of levels of evaluation- that only seem to work Monday-Friday from 9-5 and everyone seems to say, “Not my kid.”
- I cannot site any rules. When we have had kids the Juvenile Department/DHS indicate need a “mental health” bed, we receive resistance from the community mental health provider indicating the youth does not meet the criteria to qualify for such a placement. However, when I reschedule the hearing and tell Juvenile Department/DHS to advise the community mental health director to attend, a placement is then found before the scheduled hearing.
- History of starting fires; history of sex abuse’ disagreements about severity of diagnosis and need for treatment and type of treatment.
- Eligibility for crisis bed depends upon youth’s condition at one moment in time, it does not appear that there is a system for assessment of a pattern of symptoms over time that indicate the need for a high level of intervention.
- Less than clear diagnosis indicated no one willing to undertake it.
- I have seen assessments that include a D/A issue and then that precludes placement for an obvious and overriding mental health issue.
- One disqualifier is youth with sexual offense related allegations pending.

4. How many times in the last year has a youth in need of a mental health or crisis placement been unable to be released from detention because there was no safe place for the youth to be released to?

0	2	7%
1-3	15	52%
4-6	6	21%
7-10	2	3%
11-20	4	14%
More than 20	1	3%

Responses Received:	*29*
No Response Given:	*3*

5. Do you believe the length of detention stays could be reduced for youth with mental health needs if residential and crisis beds were readily accessible?

YES	29	100%
NO	0	0%
	Responses Received:	*29*
	No Response Given:	*3*

6. Have you had any cases involving youth who had to be released to the emergency department or psychiatric ward of a hospital because there was no other appropriate placement available?

YES	8	27%
NO	22	73%
	Responses Received:	*30*
	No Response Given:	*2*

7. If yes, please estimate how many in the last year:

1-3	6	75%
4-6	1	13%
7-10	1	13%
11-20	0	0%
More than 20	0	0%
	Responses Received:	*8*
	No Response Given:	*-*

8. How many times in the last year did you commit a youth to OYA primarily because there were no other options available at the local level to serve the youth's mental health needs?

0	8	27%
1-3	17	57%
4-6	4	13%
7-10	0	0%
11-20	1	3%
More than 20	0	0%
	Responses Received:	*30*
	No Response Given:	*2*

9. Do you believe there are culturally appropriate services available to serve all delinquent youth in your jurisdiction?

YES	8	27%
NO	22	73%
	Responses Received:	*30*
	No Response Given:	*2*

10. What reforms do you think are needed in your jurisdiction to better handle juvenile delinquency cases involving youth with mental health needs?

Emergency placement options where youth can decompress and be assessed	27	90%
More residential placement beds	27	90%
Evidence-based, mental health interventions in the community	22	73%
Early screening, assessment and diversion	21	70%
In-home treatment options	19	63%
Continuity of care between systems	19	63%
Psychiatric services	17	57%
Improved systems for mediation prescribing and management	12	40%
More treatment options for youth with private insurance	11	37%
Other (please specify)	2	7%
	Responses Received:	*30*
	No Response Given:	*2*

Responses provided under “Other”:

- There needs to be someone accountable for these services. I have been EXTREMELY frustrated in trying to determine who the gatekeeper for services is. I cannot get a straight answer. The responsibilities are so scattered that everyone points a finger at someone else.

- The health care issue- ex. kid has no meds- his prescriber retired- dad not attentive- kid headed to shelter care in 4 days- kid has no health card until he gets there- so cannot get his meds but without meds he is most likely to act out at shelter and be back to detention. Often I hear- we have no appropriate mental health facility. Getting a kid to Children's Farm Home is an act of Congress- unless they are in correctional facility and act up. Question #8 above- should have clarified commit to OYA for residential or correctional- answer for me is different.

Children's Mental Health Increased Emergency Department Visits

Crisis Workgroup Recommendations

November 8, 2014

OVERVIEW

A number of hospitals in Oregon are experiencing increasing challenges in serving young people who go to emergency departments for behavioral health challenges. Youth are waiting in emergency departments or pediatric hospital rooms, sometimes for many days, due to a lack of options for safe, therapeutic services. Families, health care providers and insurers are concerned about this growing problem. "Psychiatric boarding," as it is called, is unlikely to be therapeutic, is at times traumatic for young people, their families and hospital staff, and it creates logistic and financial problems for hospitals. This problem is national as well as local.

Services, policy and practice within the children's system of care are all connected, and any element can affect how the system functions as a whole. With this in mind, the Addictions and Mental Health Division (AMH) convened a two-session workgroup to evaluate data and solicit expert opinion on the problem's contributing factors and possible solutions. The workgroup included representatives from emergency departments, psychiatric units, pediatric units, sub-acute psychiatric residential treatment programs, community mental health programs (CMHPs), intensive community-based treatment service providers, child welfare, private insurance, coordinated care organizations (CtOs), family members, and young adults.

The following is a summary of contributing factors identified and recommended solutions made by the workgroup.

CONTRIBUTING FACTORS

Capacity and continuum of care

- The number of children enrolled in Medicaid since 2005 has doubled and has increased by 40,000 since January 2014.
- The number of psychiatric hospital beds has not changed in 20 years.
- The use and availability of residential care has diminished.
- Many areas do not have acute intensive diversion programs.
- When family crises occur, only limited numbers of respite programs are available to support kids while things calm down.
- When youth in foster care have behavioral crises and cannot go back to their current homes, there are limited safe alternatives.
- Members of the system of care at times fail to develop timely discharge resources for youth and families in higher levels of care. This results in youth waiting for placement, creating a cascade of delays in access to all levels of care.
- Access to child psychiatric assessment is poor, due to inadequate numbers of providers in many areas of the state.

Coordination and Referral

- Families do not know what services might be available for acute needs, so they use the emergency department for services that may be available in the community.
- Families use the emergency department because they are frightened and are not certain that they can get the intensive services they need in a timely manner.
- CCOs and private insurance representatives do not have real-time notification of emergency department use by their members.
- Privately insured clients lack care coordination.
- Bed availability data is lacking, which leads to inefficient matching of needs with placements.

Payment methods

- Fiscal incentives or disincentives are not aligned with good care. For example, emergency visits, regardless of whether they are for a medical or mental health crisis, are covered as a

flat rate under a medical code rather than a mental health code.

- Many commercial insurers require that deductibles are collected in full for an emergency department or hospital stay, before a patient can be admitted to sub-acute levels of care. This creates an enormous burden for families and further disrupts discharge planning.
- The system is very difficult to navigate; multiple payers can be involved, and all of them may have different benefit packages.
- CCOs and commercial insurance companies have different review practices and ways of authorizing various levels of care.
- Many commercial insurers do not have contracts with acute diversion programs –the kind of programs that offer intensive outpatient care.
- Funding is from a wide variety of sources, including private payers and local, state and federal programs; this complexity can have a negative impact on the array of services available and what is known to be available.

RECOMMENDED SOLUTIONS:

Qualities of effective strategies will:

1.) Be systemic, coordinated and collaborative, rather than directed only at single points in the continuum of care.

2.) Include all payers in a local community, including CMHPS, private insurance and CCOs.

3.) Develop locally –each community has unique strengths and systems in place to address these issues.

4.) Be trauma-informed .

5.) Be culturally responsive.

6.) Involve family and youth input at early stages of development.

7.) Include relationships with system navigators (peer or professional) as a core strategy.

Capacity and continuum of care

- Estimate the capacity needed at acute and sub-acute levels based on analysis of current context for each community. For example, what level of preventive and diversion resources are possible and probable, and how would that influence the numbers of beds needed in the short, medium and long term?

- Increase the use of community-based crisis stabilization approaches, which should include:
    - Crisis diversion teams; and
    - Respite strategies, including facility-based respite for youth in foster care.
- Develop hospital-based acute care mental health treatment and referral services that will support youth and families when they arrive in the emergency department, or co-locate outpatient crisis stabilization teams that can support the family until the youth gets into care.
- Form community resource teams that will actively work toward discharge to lower levels of care for young people who are in higher levels of care.

  This is particularly needed for youth who are not enrolled in Wraparound. Teams should represent the Department of Human Services, Oregon Youth Authority, education, mental health providers, peer support specialists, and insurance providers (CCO or commercial). This should be done proactively and as soon as possible.
- Increase access to acute telemedical services in remote community emergency departments, hospital units, and outpatient settings.
- Increase support services for young people, both in school and after school, to engage them in positive, productive, and supportive social activities.

Coordination and referral

- Create a standard method of informing payers when their members go to emergency departments and hospital units.
- Create an electronic data base of available acute resources statewide.
- Create effective tools for educating families about the options they have to access routine and acute mental health services, by both insurer and location.
- Make sure that young people and their families who seek care in the emergency department or hospital receive coordinated connection to outpatient care, regardless of the disposition of their case.

Payment methods

- Remove up-front deductible payments that commercial insurers require of members who access acute care services.
- Allow emergency departments to bill for mental health services to young people in such

a way that they will be reimbursed for the care they provide.

- Take a closer look at the "funding silos" that impede implementation of effective diversion strategies.

- Increase use of flexible funding pools to address needs that are not traditional medical services and thus not covered by traditional payers.

Oregon Health Authority role:

The Oregon Health Authority (OHA) is responsible for ensuring that children and families everywhere in the state receive the health services they need, and that the crisis services that are available are adequate to meet those i:ieeds. The children's mental health system must have capacity to mitigate crisis and to work with the family to plan for ongoing services that will address the underlying issues. Each community's unique strengths and resources will define its strategies and solutions to creating a rapid yet therapeutic response to families faced with a behavioral health crisis. Strategies to improve local options must be developed at both state and local levels.

1.) AMH has included this challenge as part of its 2015-2018 Behavioral Health Strategic Plan. One immediate action taken by OHA will be to develop a way to track the length of time that clients stay in emergency departments waiting for resources. This would be one benchmark of the system.

2.) OHA will pilot two or three diversion programs to evaluate how well they reduce use of emergency departments for mental health crisis needs.

Amy Baker, M.S.W.
Child and Family Mental Health Manager
Addictions & Mental Health
Oregon Health Authority

Ajit Jetmalani, M.D.
Consulting Child Psychiatrist
Addictions & Mental Health
Oregon Health Authority