

# SCREENING, ASSESSMENT AND TREATMENT:

# INDIANA ADDRESSES MENTAL HEALTH IN JUVENILE DETENTION CENTERS

By JauNae M. Hanger

The Indiana Juvenile Mental Health Screening, Assessment and Treatment Pilot Project is an innovative, cross-disciplinary effort to establish routine, systematic screening, assessment and treatment in juvenile detention facilities in Indiana.<sup>1</sup> This effort recognizes that a substantial number of youths in the juvenile justice system have unmet mental health needs, and the existing system is largely unable to respond effectively to those needs. The Indiana pilot project is modeled after, and builds on, a similar, seven-year project conducted in Pennsylvania that recently resulted in 20 of 22 youth detention centers implementing systematic mental health screening of all residents.<sup>2</sup> Like its Pennsylvania counterpart, the Indiana pilot project expects to become a statewide initiative. A key expectation and goal of the project is to help local counties develop partnerships that link youths with appropriate community-based services when they first enter through detention, in an effort to prevent or avoid the youth's deeper involvement in the juvenile justice system.

## Mental Health as a Concern For Detention

Nationally, research shows that up to 75 percent of youths in detention centers demonstrate diagnosable mental health disorders.<sup>3</sup> In Indiana, a recent study of youths in detention confirmed that more than 50 percent of youths have diagnosable mental health problems.<sup>4</sup> Many of these youths end up in the juvenile justice system after having failed to be identified, or gone undiagnosed, and having not received services in their communities. A significant number of youths who enter detention are low-level offenders, and many of them are believed to have the potential to remain within their communities, at home and in school, if they have access to appropriate community-based services.

Although there are a few county detention centers in Indiana that have instituted systematic screening, assessment and treatment of juvenile justice youths, most have not. Without the appropriate tools to identify these youths and systems in place to respond with adequate supervision and care, detention centers are ill-equipped to manage care and safety issues related to these youths. Heightened risk of suicide, greater potential for self-harm, and higher incidences of peer-on-peer bullying and victimization are important concerns. Without proper custodial care, some youths may present a safety risk not only to themselves but to staff and other detainees.

The consequences for youths with unaddressed mental health needs can be severe. Data indicate that youths who go without appropriate services stay incarcerated longer and risk much higher rates of recidivism.<sup>5</sup> Their mental health conditions may worsen, and their ability to be reintegrated successfully into the community may decline. The cost to communities during the lifetime of that youth may be great as well. On average, it costs three times more to house a youth in a juvenile correctional facility than to pay for him or her to go to school.<sup>6</sup> The financial costs to society continue to increase if the child moves on to the adult criminal justice system. Such societal costs — in terms of reduced productivity, increased welfare benefits, and the direct costs of prosecution and confinement — build over time if the youth continues to offend as an adult.

## Pilot Project Beginnings

The Indiana pilot project is a culmination of work that started in 2003 when the Indiana State Bar Association (ISBA) Civil Rights of Children Committee sponsored a continuing legal education seminar *Children, Mental Health and the Law: Breaking Barriers to Care*. This seminar involved a series of cross-disciplinary panels, drawing from the legal

community, education, social work, mental health, government and child advocacy. The dialogue that started during the seminar focused on why more and more youths with immediate and unaddressed mental health needs were coming through juvenile court and what a juvenile defender should do to ensure that those youths receive court-ordered mental health assessments prior to disposition. That dialogue identified a number of systemic barriers to accessing care and, at the same time, created an atmosphere of opportunity that has continued to this day.

The ISBA Civil Rights of Children Committee chose to continue the work it started in 2003 by organizing a statewide conference the following year. On Aug. 27, 2004, more than 250 individuals — lawyers, legislators, government officials, judges, doctors, mental health professionals and educators — gathered in Indianapolis to hear more than 60 national, state and local experts discuss barriers to care and potential solutions as part of the Children, Mental Health and the Law Summit. A year later, ISBA issued the *Official Report on Summit Findings with Recommendations*. An important recommendation was to institute systemic screening, assessment and treatment of youths entering the juvenile justice system in Indiana. It was that recommendation that became the catalyst for the Indiana pilot project.

## Moving Forward

The Indiana pilot project is in its second year of funding by the Indiana Criminal Justice Institute. In the last year, a statewide advisory board was formed to guide the project. Members of the advisory board include legislators; government agencies dealing with child welfare, mental health, education and corrections; juvenile court judges from multiple counties; legal professional associations for probation, juvenile detention, state bar, public defenders and prosecuting attorneys; and medical and mental health representatives — a university adolescent psychologist and one representative from a pediatric physician association, a mental health community centers organization and a minority health coalition.

A selection process to choose the initial county participants was devised by the advisory board. Six geographically-diverse Indiana counties — Lake, Porter, Marion, Bartholomew, Clark and Johnson — were selected to be the pilot counties after having submitted detailed proposals demonstrating their commitment to the pilot project goals and objectives. Representatives from those counties have been added to the advisory board and to the various committees that worked during the last six months of 2007 to ready the pilot project for implementation. The counties have developed their own protocols and participated in training so that actual screening, assessment and treatment (referrals) could begin Jan. 1, 2008.

The pilot project has selected the Massachusetts Youth

Screening Instrument, Version 2 (MAYSI-2) as its screening device and is using the “train the trainer” modules provided by the National Youth Screening Assistance Project, a program of the Department of Psychiatry, University of Massachusetts Medical School. The MAYSI-2 is a 52-question, yes-no screening device that has six clinical subscales, which help identify a youth’s mental or emotional distress. An important aspect of the pilot project is collecting prevalence data through the MAYSI-2 software so that local and state policymakers can use this information to assess the need for services and make future funding decisions. Data will also be collected to help assess the impact of the pilot project on recidivism among detention center youths.

During the next year, the Indiana pilot project will work with the counties to help build local capacity to obtain treatment for youths; explore opportunities for diversion of youths with mental health needs into community-based services; and identify important mental health/correctional training opportunities, including behavioral management training for detention center staff. In June 2008, the advisory board will consider additional counties to start the project in 2009, contingent upon available funding. An interim evaluative report of the pilot project is expected at the end of 2008.

## A Collaborative Model

The fact that so few Indiana detention centers have thus far instituted routine screening, assessment and treatment is a reflection of a number of systemic barriers. The Indiana pilot project has embraced a model that addresses these

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concerns head-on. Although Indiana Juvenile Detention Standards require suicide and mental health screening, there is no nondisclosure provision in state or federal law that protects mental health information elicited through screening devices, such as the MAYSI-2, when they are administered to youths by non-medical, detention center staff. Yet, the information to be elicited is medical in nature, bearing directly on the health status of the youth and his or her need for mental health services. This same information, however, has

the potential to compromise the youth’s due process rights against self-incrimination if it was shared for reasons other than obtaining services for the youth.

The pilot project has adopted a mental health model, using state mental health records law (Indiana Code 16-39-2 et seq.) and federal law (the Health Insurance Portability and Accountability Act of 1996 — HIPAA, see privacy standards, 45 C.F.R. 160 and 164). This model requires that participant counties have their juvenile justice agencies — court, probation, prosecution and public defender — sign a memorandum of understanding and a business associate agreement that obligate them to treat the information from

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screening, assessment and treatment confidentially, to be used solely for the purpose of obtaining services. A principle of limited disclosure is operational throughout the model; only as much information as necessary to obtain the services is to be disclosed. In this model, the juvenile defender is concurrently informed of information disclosed to other juvenile justice officials. The family's involvement in assessment or treatment referrals is sought as well.

Last spring, the ISBA Civil Rights of Children Committee, in cooperation with members of the pilot project advisory board, was successful in getting a law passed that prevents the use of information obtained through screening, assessment or treatment in the juvenile justice system from being used for purposes of guilt in adjudication proceedings (Indiana Code 31-32-2-2.5). This law and the above policies regarding confidentiality and disclosure are important to achieving cooperation among juvenile justice officials so that appropriate services may be obtained for youths who need them while in detention.

Another major focus of the Indiana pilot project is a detention center's link to treatment. The pilot project protocols require that county sites respond by seeking assessments or evaluations for youths who score in a caution range for suicide ideation or in the warning range in two different MAYSI-2 subscales. The pilot project has adopted guidelines for counties to set up local advisory boards similar to the advisory board that operates at the state level, so that collaborative partnerships regarding treatment may result and/or be strengthened at the local level.

Finally, helping counties address issues associated with the interruption of Medicaid funding once a youth enters the juvenile justice system is another goal of the pilot project. In Indiana, a youth may lose Medicaid funding upon entering detention or incarceration. The loss of Medicaid funding may impact the youth's access to services and continuity of care. Potential policy changes in Medicaid funding at the state level that would allow youths to retain funding or minimize disruptions in funding, and the development of diversion models that involve appropriate youths being diverted from entering detention in the first place, are being explored. Connecting a youth with community-based services as part of a diversion program can be a means to maintain critical Medicaid funding.

## Conclusion

With this pilot project, partnerships are being formed at the county and state level and among county and state stakeholders across various disciplines that traditionally have not coordinated their efforts for juvenile justice youths. These partnerships are making it possible to change the paradigm in Indiana of how and when juvenile justice professionals respond to youths with mental health needs in the juvenile justice system. Abandoning a punitive approach for one driven by treatment goals increases the likelihood that such youths, many with serious mental health needs, will truly be helped.

## ENDNOTES

<sup>1</sup> The Indiana Juvenile Mental Health Screening, Assessment and Treatment Pilot Project is chaired by Judge Mary Harper, Porter County Circuit Court. Project direction is provided by the staff of Laurie Elliott & Associates and the Youth Law T.E.A.M. of Indiana.

<sup>2</sup> The Juvenile Detention Centers Association of Pennsylvania served as project director for the JDCAP Mental Health Grant.

<sup>3</sup> Teplin, Linda A., Karen M. Abram, Gary M. McClelland, Mina K. Dulcan and Amy A. Mericle. 2002. Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59(12):1133-1143. (December).

<sup>4</sup> Glick, William N. and Mistie Morales. 2004. *Indiana juvenile detention mental health and substance abuse assessment project*, summary statistics. Indianapolis: Indiana Juvenile Justice Task Force Inc.

<sup>5</sup> Tulman, Joseph. 2004. Special education advocacy for young people in the delinquency and criminal systems. Presentation prepared for the Children, Mental Health and the Law Summit, 27 Aug. in Indianapolis. Available at [www.inbar.org/content/news/article.asp?art=339](http://www.inbar.org/content/news/article.asp?art=339).

<sup>6</sup> Stanczykiewicz, Bill. 2005. *Don't give up on juvenile offenders*. Indianapolis: Indiana Youth Institute. (June). Retrieved on Oct. 29, 2007, from [www.iyi.org/media/articles\\_details.asp?ArticleID=253](http://www.iyi.org/media/articles_details.asp?ArticleID=253).

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