



Project Connect: Linking juvenile probationers to mental health providers

**Gail A. Wasserman, PhD
Larkin S. McReynolds, PhD**

**Center for the Promotion of Mental Health in Juvenile Justice
Columbia University, Division of Child Psychiatry
www.promotementalhealth.org**

wassermg@childpsych.columbia.edu

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Strong Interest in Managing Suicide Risk in Juvenile Justice

Suicide risk in juvenile justice youth greater than for others

- History of aggressive or antisocial behavior
- Access to weapons
- Co-occurring mood and substance use disorders
- Increased school difficulties
- Family Issues:
 - Youth's not living with parents and/or family discord
 - Family history of mental health/substance use problems
- Poor problem solving skills
- Of all Utah youth suicides (<18 yrs), **80%** had been in contact with the juvenile justice system in the 12m before death (Gray et al, 2002)

Pre-existing mental illness a strong predictor of suicide



- Over 90% of adolescents who commit suicide suffered from an associated psychiatric disorder at the time of death.
- In 63% of completed suicides, psychiatric symptoms developed more than a year prior to death.
- In only 4% of cases, psychiatric symptoms developed 3 months immediately prior to suicide.

Most justice youths' mental health problems are untreated and unknown

- Among community adults, nearly half of lifetime cases of impulse control or substance use disorder have received no Rx
- Among those w mood disorders, delay from appearance to first Rx is 6-8 years
 - Delay longest in males, those w less education, those of minority ethnicity, those w earlier onset

Findings from the National Comorbidity Survey, Wang et al (2005) ArchGenPsychiat

Current identification and management procedures for suicide risk in JJ insufficient



- Recommendations (like those of NCCHC, OJJDP) and procedures do not apply to most juvenile justice youths
 - Most juveniles with justice contact are not confined, but managed in their communities
 - Nationwide, only 16% of cases petitioned (9% of those arrested) result in secure placement, with the remainder returned to their communities
- Need for screening at juvenile justice entry points

Implementing standards lowers suicide risk for incarcerated youth



- OJJDP's 2000 Juvenile Residential Facility Census (n=3690 facilities)
- Facilities with universal screening within first 24 hrs of intake reported significantly fewer serious suicide attempts (OR=.45, $p<.01$),
 - regardless of facility size or whether youth come from another facility within the system
- Detention centers, privately owned facilities and those without on-site MH care reported significantly more serious attempts



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- Juvenile probations is an **excellent** public health setting in which to screen for suicide risk
 - **But...** justice settings need to develop assessment strategies that differ from those used in clinical settings
 - High rates of disorder
 - Many youths in crisis
 - For many youths, the first opportunity for mental health scrutiny
 - Minority youths, those from families with fewer resources, less likely to access services in their communities

Implementing NYS' Adolescent Suicide Prevention Plan

- **SAMHSA-funded Project Connect**
 - 4 NYS counties (Albany, Broome, Onondaga, Orange)
 - Planning meetings between county probation and mental health to develop linkage protocols
- **Project Connect's 3 phases**
 - Baseline record review
 - 2 day training
 - Implementation and Follow-up
- **Current planning for 3-year supplemental funding for additional counties**

Project Connect relies on a public health approach to mental health assessment



- Proactive case identification
 1. Systematic screening
 2. Consistent, sound and accurate approach to instruments (DISC, DPS)
- Clear protocols for how to move from assessments to treatment
 3. Decision trees for referrals
 4. Local Resource Guides
 5. Two-day didactic training
- Evaluation of impact of new procedures on practices

Preliminary baseline data

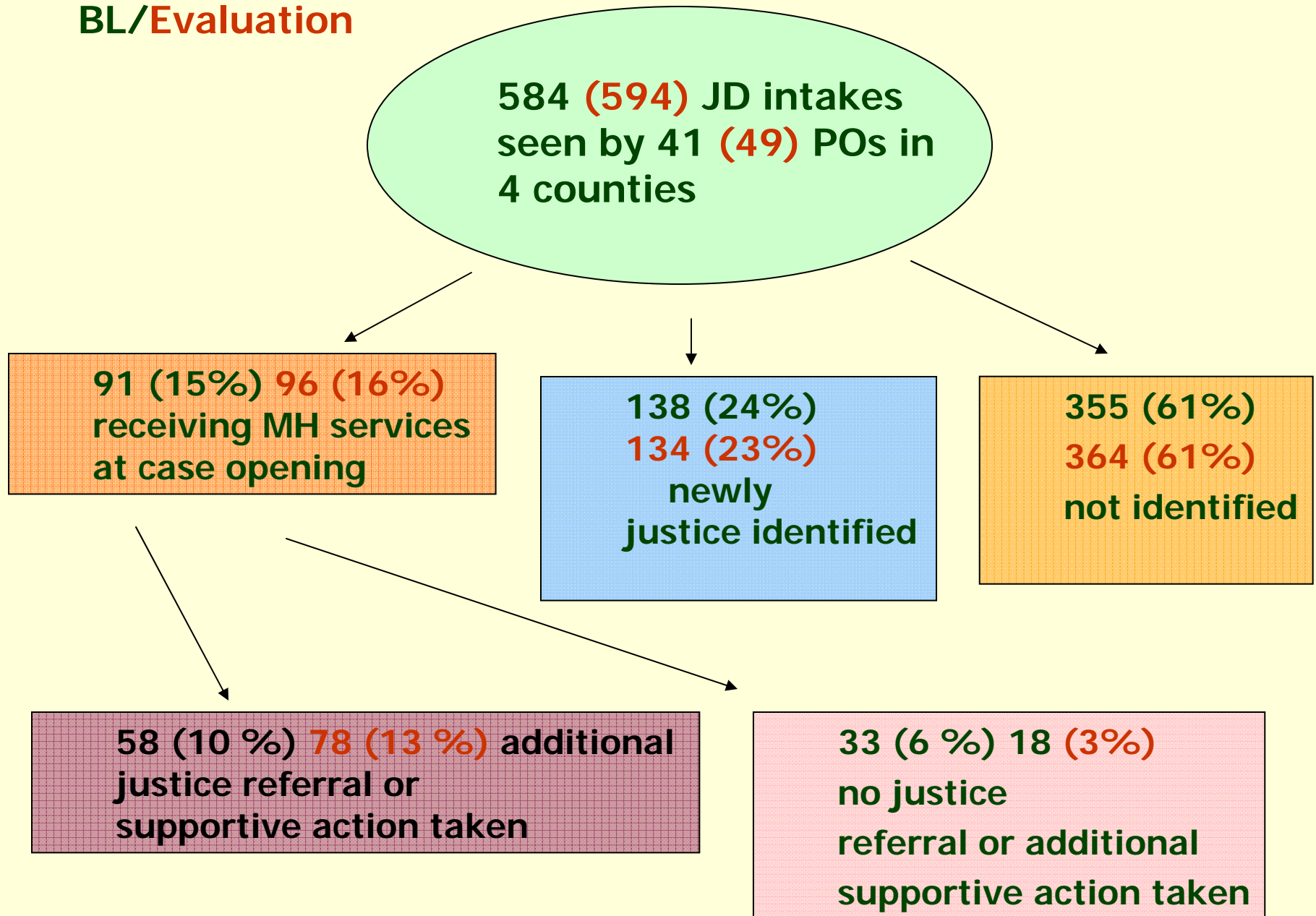


- Charts for 584 new delinquent intakes, with 41 POs, reviewed
 - 70% Intake/diversion
 - 28% Probation supervision
- Average youth was white (46%) or African-American (42%) male (73%) 14 year old
- Two-thirds were first offenders
- One third committed persons or weapons offenses

No differences across conditions in “MH Identification”

- Defined as....
 - Court ordered MH services
 - PO supervision plan included MH services
 - PO made appointment at known MH agency
 - Youth accessing MH services at case opening
 - Indication that youth accessed services post probation intake
- Despite MH agencies’ preliminary concerns, we did not “flood” system with “new” or “unwarranted” referrals.

BL/Evaluation



Linkage practices improve post training

	Baseline	Post training
MH Identified	138 (24%)	134 (23%)
PO referred	113 (82% of id'd)	117 (87% of id'd)
PO implemented*	52 (38% of id'd)	80 (60% of id'd)
PO confirmed initiation *	51 (37% of id'd)	71 (53% of id'd)
Services accessed***	54 (39% of id'd)	88 (66% of id'd)

Newly identified youth shown

93 of 594 (15.6%) intakes agreed to systematic MH screening



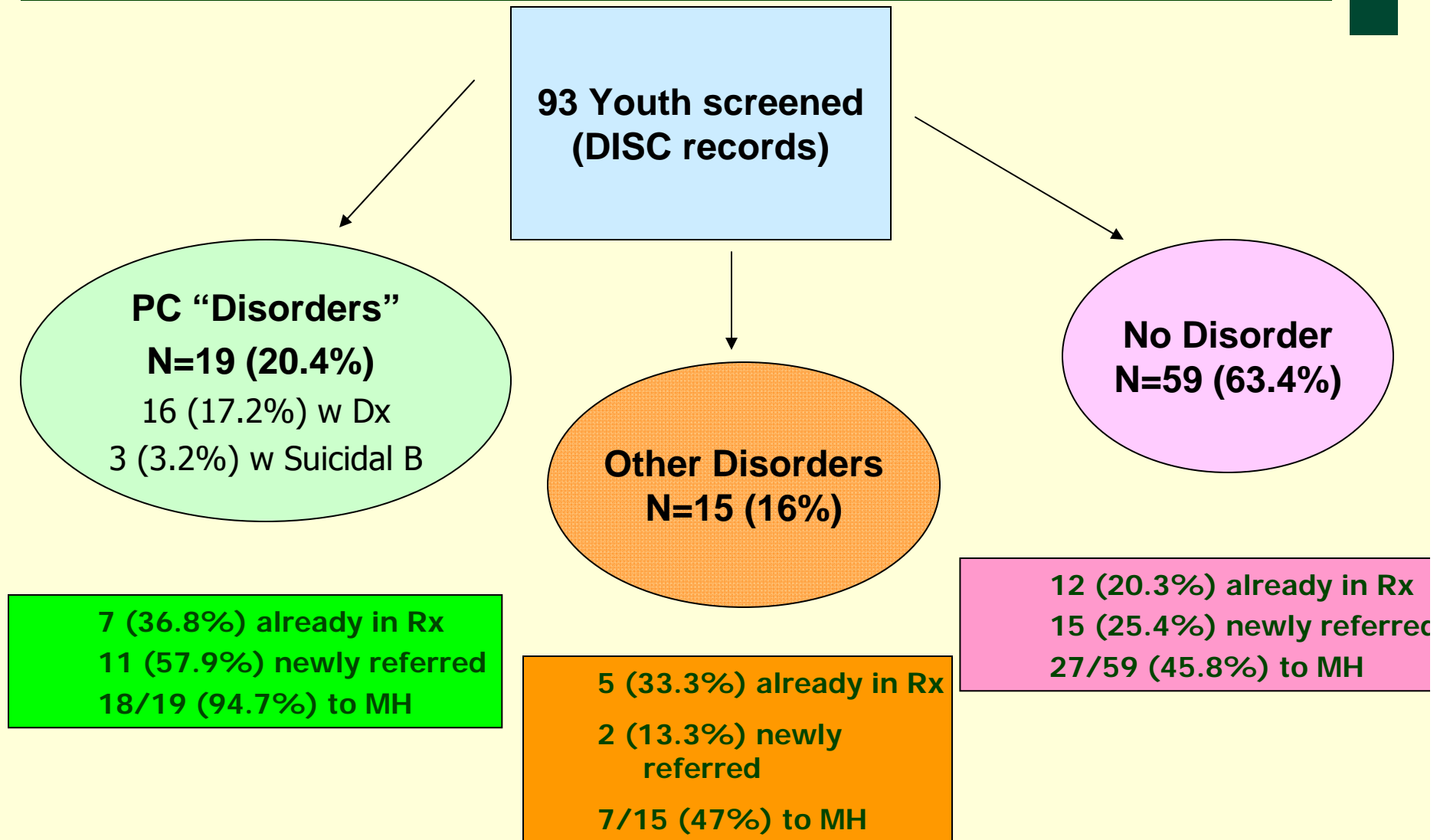
- Disorders that were to prompt referral
 - Recent suicide attempt, or ideation + plan
 - Any Substance Use Disorder
 - Any Mood Disorder (MDD, Mania, Dysth)
 - PTSD
 - Panic Disorder
 - Any of the above, at “Serious” subthreshold levels
- Other clinical conditions discretionary
 - e.g., phobias

Referral Urgency Classification



- **Class I: Emergency**
 - Recent suicidal ideation and a recent plan
 - Recent suicidal ideation and a recent attempt
 - Recent suicidal ideation and a lifetime attempt Hx
 - Plus a positive or severe subthreshold dx of Mood or SUD, regardless of impairment
 - Recent suicide attempt
 - Lifetime history of multiple attempts
- **Class II: Crisis**
 - Recent suicidal ideation with no plan
 - Youth and family can agree on safety plan
- **Class III: Non-critical**
 - Positive or severe subthreshold Dx of MDD, Dysthymia. SUD, mania/hypomania, PTSD or Panic Disorder

36% endorsed 1+ disorders, or substantial suicide risk



Targeting referrals to high risk group



	Baseline n=583	Post training, w systematic screening (V-DISC) n=93		
		PC Dx or suicide risk (n=19)	Other Dx (n=15)	No Dx (n=59)
Already in Rx	91 (15.6%)	7 (36.8%)	5 (33.3%)	12 (20.3%)
Newly referred	101 (17.3%)	11 (57.9%)	2 (13.3%)	15 (25.4%)
Σ "in MH system"	192 (32.9%)	18 (94.7%)	7 (47%)	27 (45.8%)

BL refs < **Post training** z=4.18, p < .00001 (33% vs 56%)

BL refs < **PC Dx refs** z=11.24, p < .00001 (33% vs 95%)

Do not show Reasons for referral vs other county DISCs



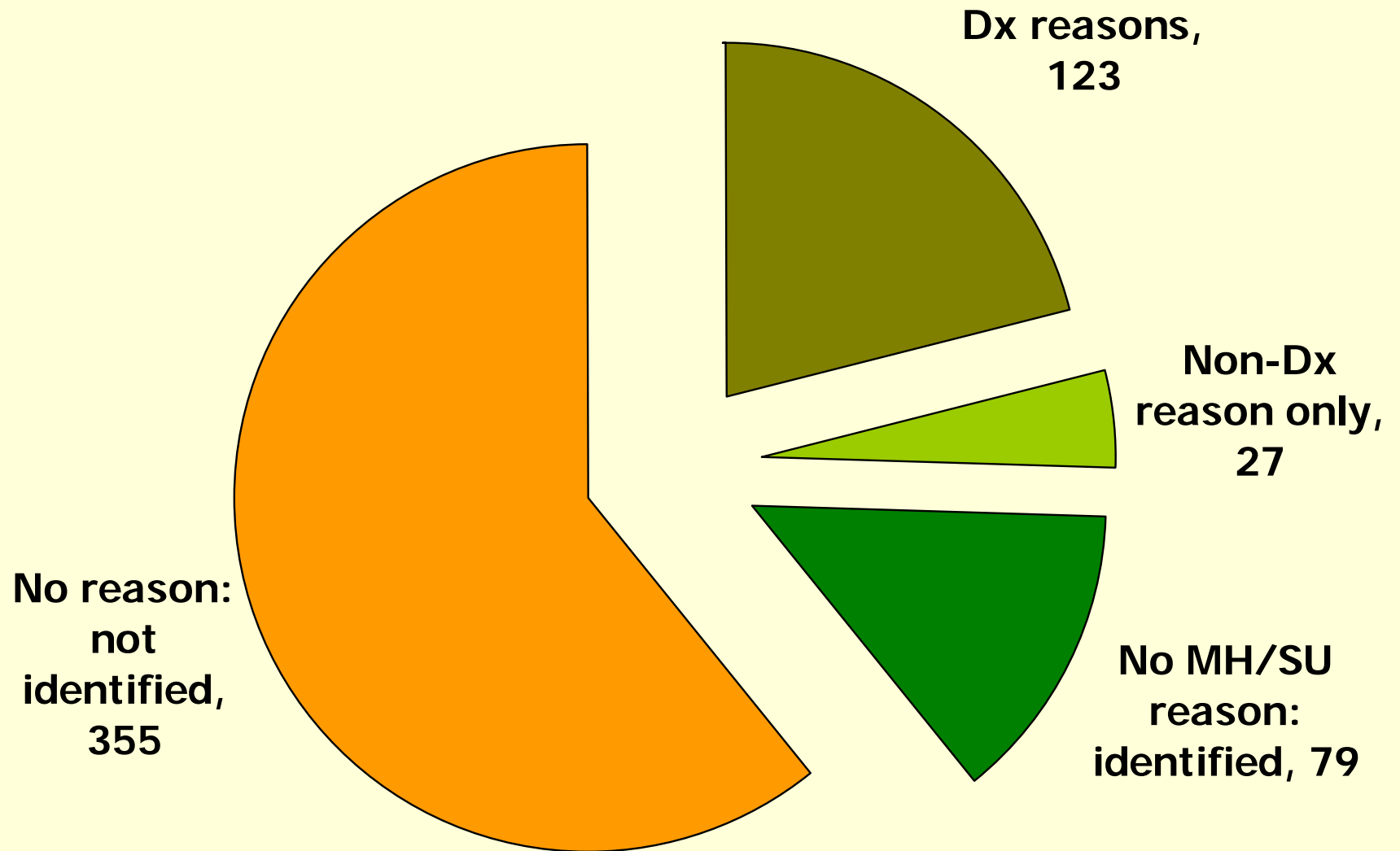
	PC Baseline	Other NY DISC
Disruptive	11.0%	19.5%
Substance Use	7.0%	11.7%
Internalizing	4.1%	20.4%
Any	19.9%	39.3%
MH Eval only	1.7%	NA
Suicide risk (current ideation)	0.5%	12.6%
Family only	9.0%	NA

Do not show Reasons for referral vs other county DISCs, and post-training DISCs

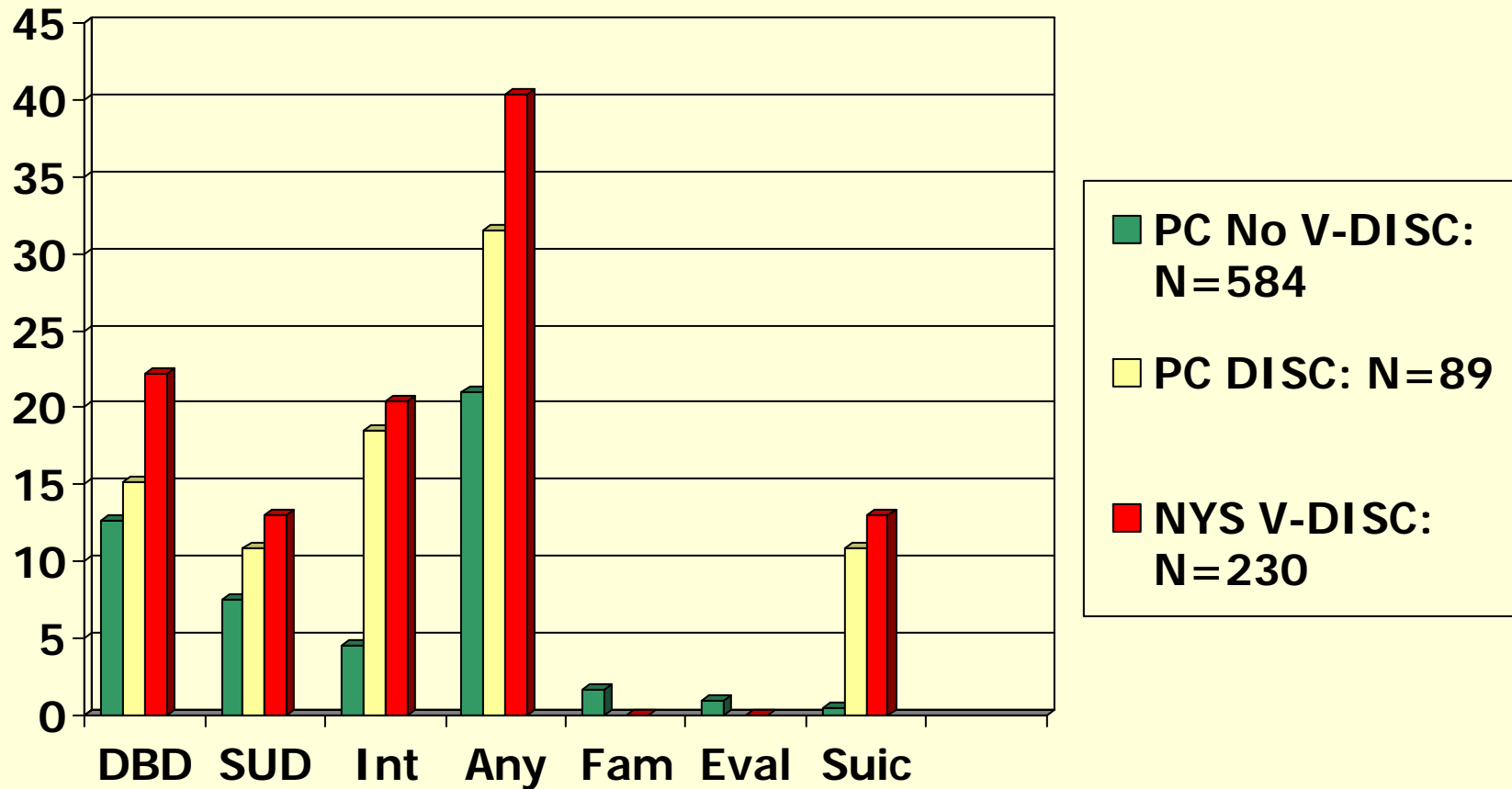


	PC Baseline	PC DISC	Other NY DISC
Disruptive	11.0%	15.2%	19.5
Substance Use	7.0%	10.9%	11.7%
Internalizing	4.1%	18.5%	20.4%
Any	19.9%	31.5%	39.3%
MH Eval	1.7%	NA	NA
Suicide risk (current ideation)	0.5%	10.9%	12.6%
Family	9.0%	NA	NA

BL MH/SU reasons were listed for only 65.5% (150/229) of identified youth



With V-DISC, identification of mental health and suicidality 2x high



Without systematic screening



- About half of expected are identified (49%)
 - 54% of those with substance problems
 - 50% of those with disruptive problems
 - 20% of those with internalizing problems
 - 8% of those with suicide risk
- Other research shows that families and other gatekeepers identify externalizing problems more readily than internalizing problems
 - For “hidden” concerns such as suicide risk and depression, need direct youth input to identify

Who gets identified?



- Logistic regression considering youth and PO characteristics, PO MH competency, and county MHPS Rating

County MHPS Rating (US HRSA, SAMHSA)



1. The area is a rational area for the delivery of MH services
2. One of the following conditions prevails:
 - The area has either
 - Population-to-core-MH-professional $\geq 6,000:1$ and a population-to-psychiatrist $\geq 20,000:1$
 - Population-to-core-MH-professional $\geq 9,000:1$
 - Population-to-psychiatrist $\geq 30,000:1$
 - The area has unusually high needs for mental health services, and has
 - Population-to-core-MH-professional $\geq 4,500:1$ and a population-to-psychiatrist $\geq 15,000:1$
 - Population-to-core-MH-professional $\geq 6,000:1$
 - Population-to-psychiatrist $\geq 20,000:1$
3. MH professionals in contiguous areas are over-utilized, excessively distant or inaccessible to residents of the area under consideration

Independent contributions to BL MH identification



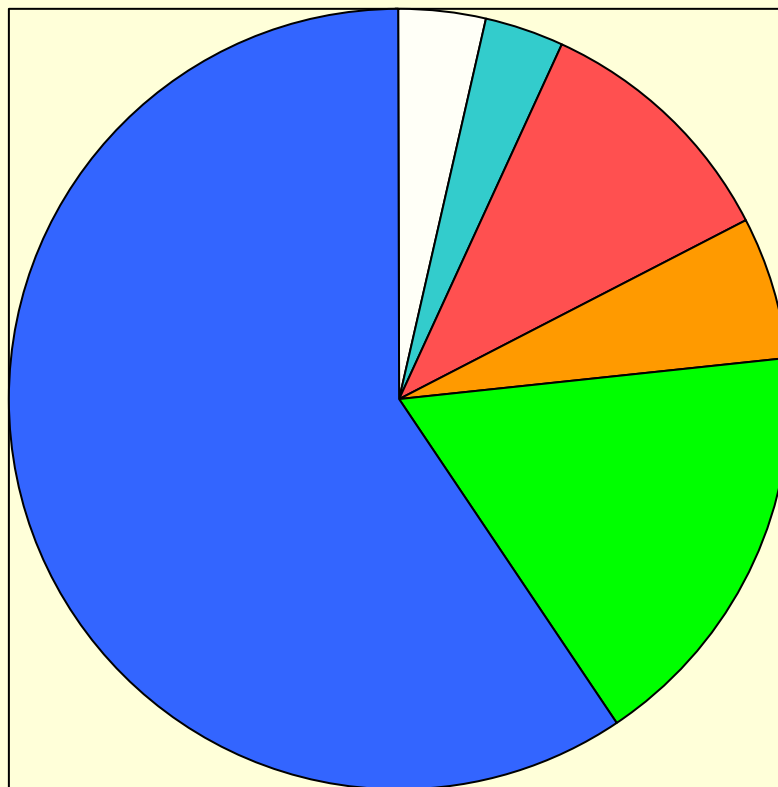
Measure	OR	Significance
Control variables		< .001
Days open	1.00	< .05
Receiving Rx at opening	2.63	< .01
Youth characteristics		< .08
Repeat offender	2.40	< .01
PO characteristics		< .05
PO MH Competency		< .001
Pre PC Knowledge	1.07	< .001
County MHPS Rating		< .001
Partial vs. No Shortage	16.6	< .001

In Baseline, characteristics of youths, POs, and the mental health system predict identification



- Repeat offenders were almost 2.5 times as likely to be newly identified
- For every item increase in a PO's knowledge score, the youth on that PO's caseload were 7% more likely to be newly identified
- JDs in counties designated as not having a shortage of mental health professionals, compared to those in a shortage county, were more than 16 times as likely to be newly identified

BL MH identification relates to a range of factors (41.3% of variance explained)



- Youth char's (3.5%)
- PO dem/occ chars (3.4%)
- PO MH competency (10.3%)
- County MHPS Rating
- Control Vars (17.1%)
- Unexpl Var (58.7%)

Detention referral study: Lopez-Williams, 2006



- Gatekeeper staff more likely to refer repeat offenders, and females
- Referred and non-referred **not** different in actual symptom levels
- Concluded that without systematic screening, gatekeepers rely on “proxy” measures of mental health need
- Leads to inefficient decision-making

Factors often linked to mental health concerns



- **Gender**
 - Girls, even in justice samples, have higher rates of mood (e.g., depression) and anxiety disorders (e.g., trauma exposure), suicide attempt risk
- **Violent behavior**
 - Those with violence histories, including current offense, at increased risk of suicide attempt
- **Substance use**
 - Substance abusers at increased risk of suicide attempt

Conclusion:



- To increase accurate identification and MH access, agencies need
 - Universal Screening
 - Systematic decision rules
 - Standard practices

Materials used in or developed for Project Connect

1., 2. Systematic screening via sound instruments



- Project Connect relies on the Voice-DISC to aid in proactive identification of youth suicide and mental health risk

The DISC-IV



- Comprehensive: up to 30 DSM-IV diagnoses and multiple timeframes (i.e., past year, past month, whole life)
- Printout of provisional diagnoses available immediately
- Most widely tested child psychiatric assessment instrument
- Administration time is approximately 1 hour



Advantages of the Voice DISC for Juvenile Justice Settings



- Increased disclosure of suicide risk and substance use
- Requires little or no reading skill
 - Self administered format: youth hears questions over headphones and keys in responses on computer
- Minimal staff support requirements
- Rates identified comparable to systematic interviewer-based procedures
- Allows for ready aggregation of prevalence data across individuals

3. Decision trees to systematize referral



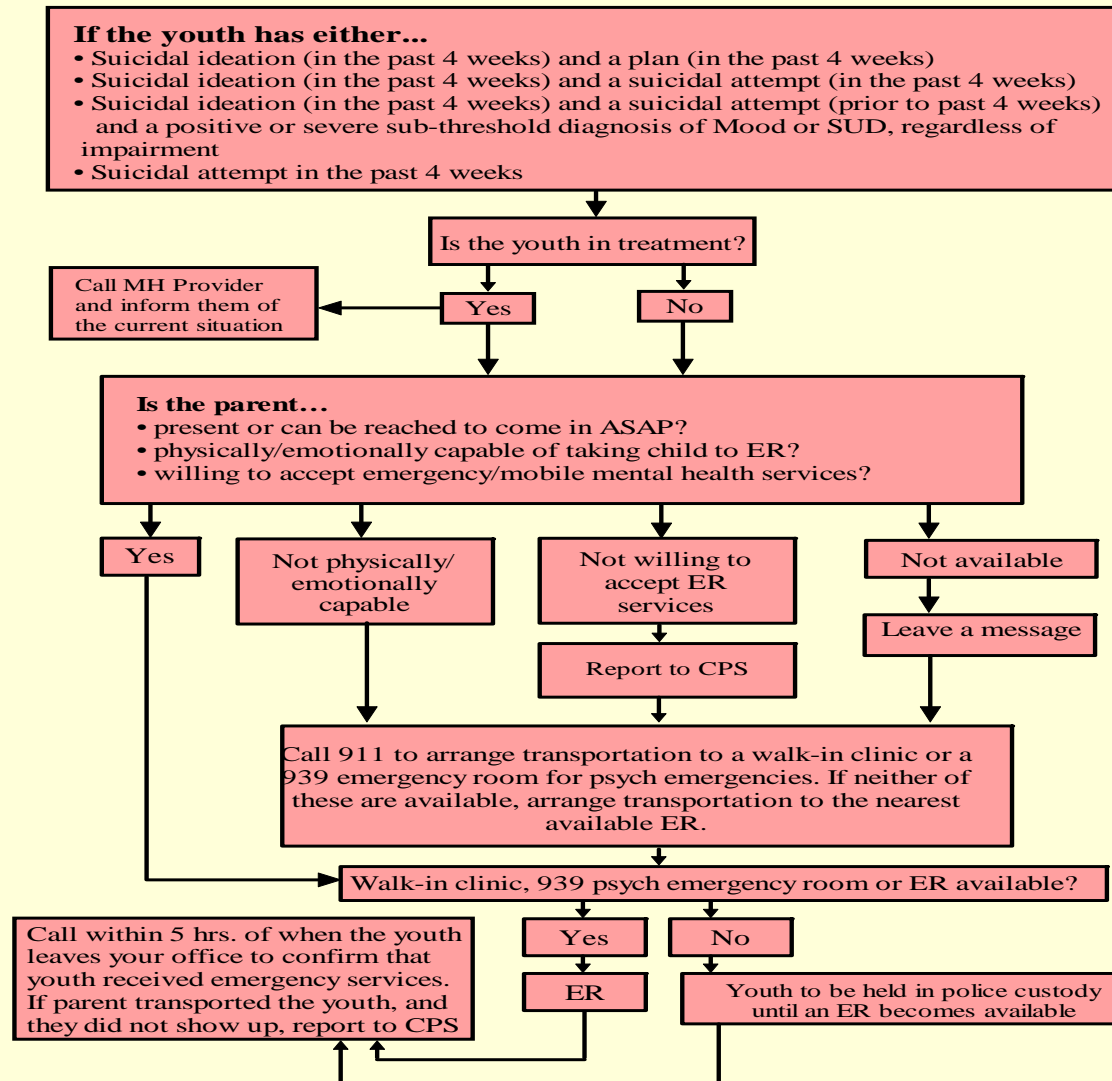
- Project Connect relies on systematic decision trees to guide POs in connecting youths to mental health services, safely and efficiently

Referral Urgency Classification

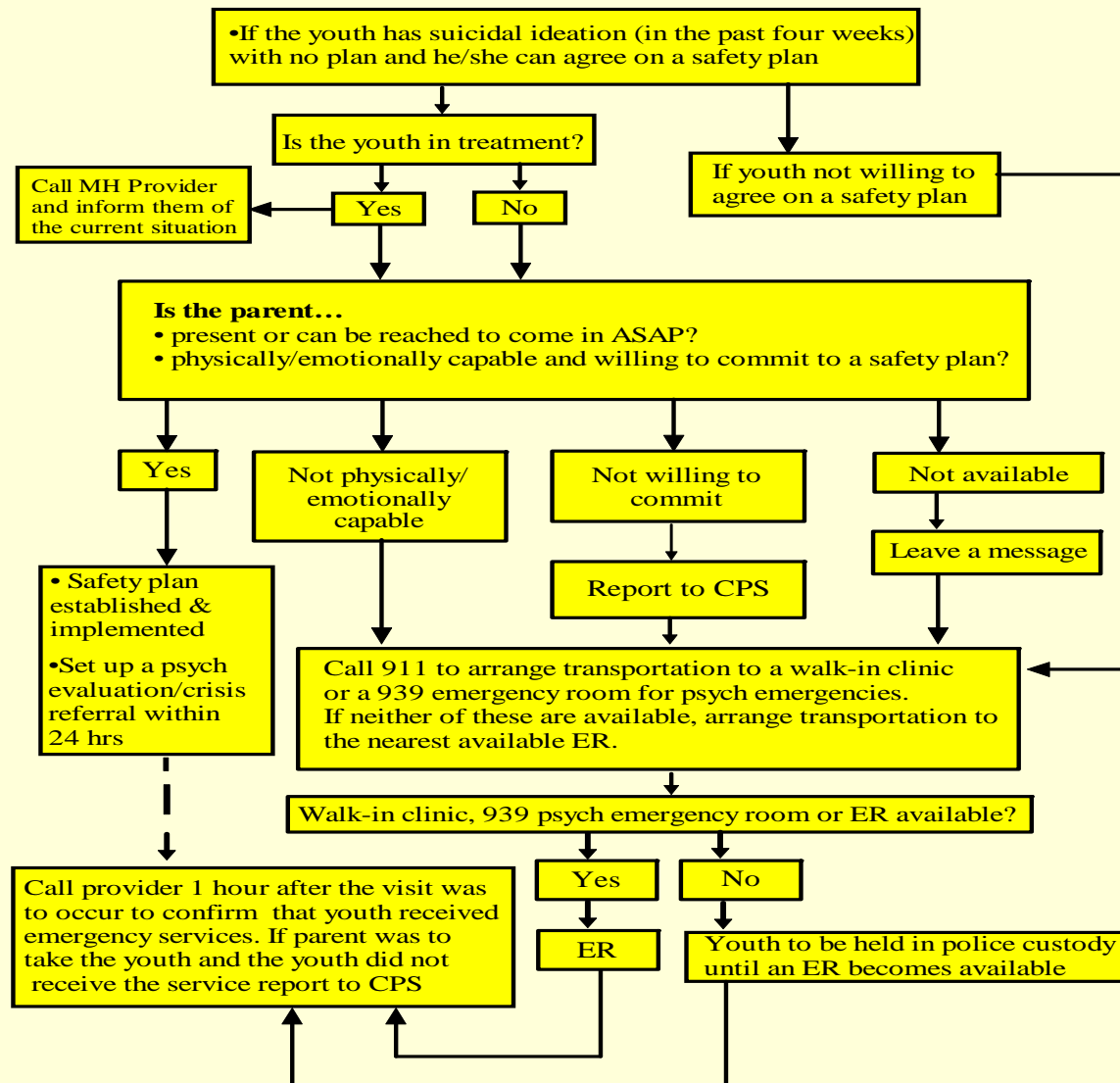


- **Class I: Emergency Services**
 - Life-Threatening Emergency:
 - Youth requires immediate intervention to prevent death or serious harm to self or others
 - Youth requires immediate evaluation within a safe environment
 - Non-Life Threatening Emergency
 - Youth requires rapid intervention to prevent acute deterioration which might compromise the youth's safety
 - Face to face evaluation should take place within 6 hours of identified need
- **Class II: Crisis**
 - Clinical Evaluation w/i 24 hours
- **Class III: Non-critical**
 - Clinical Confirmation and referral for MH Services

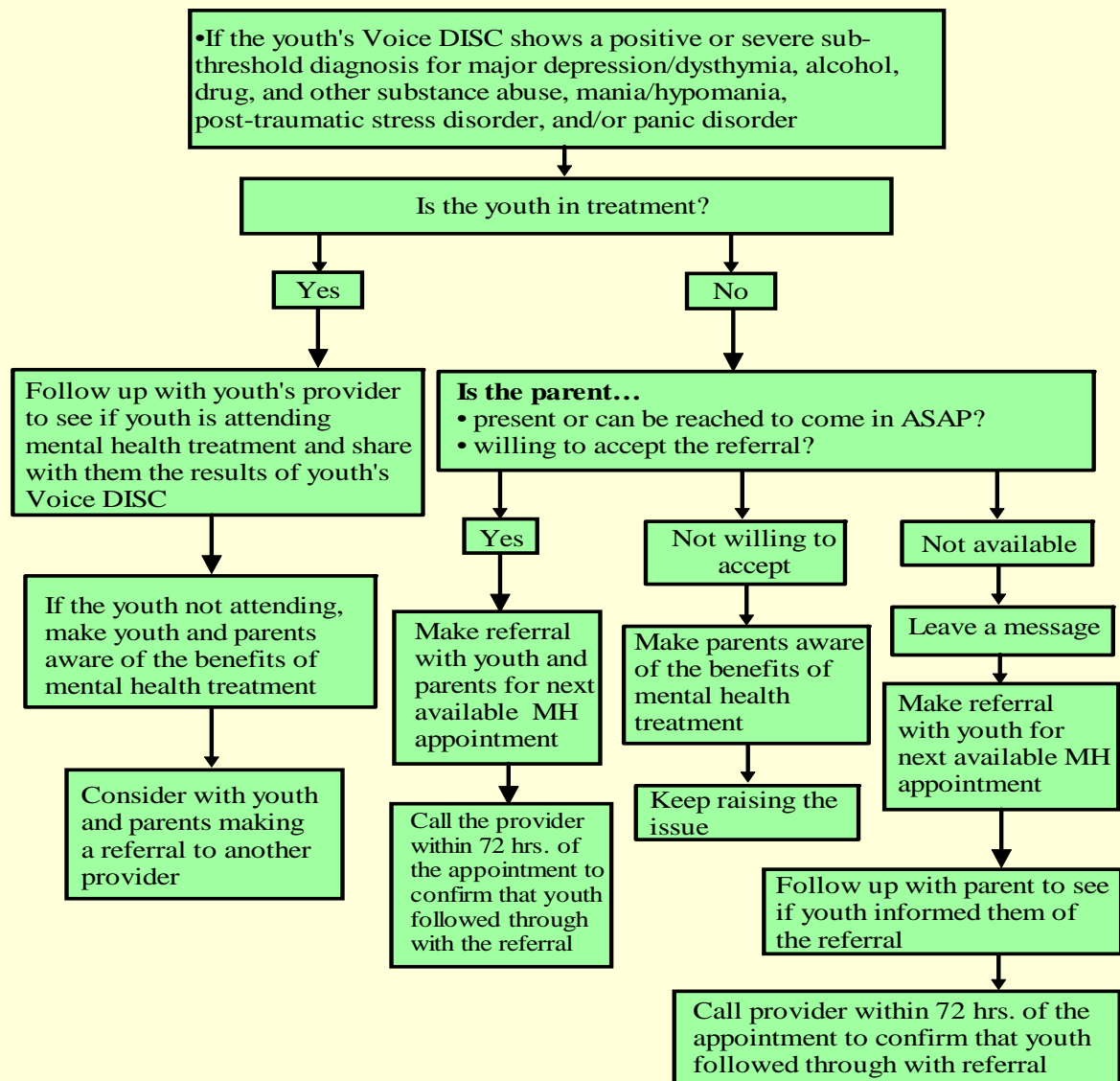
Class I: Immediate Triage/ Emergency Clinical Care



Class II: Crisis – Clinical Evaluation within 24 Hours



Class III: Non-crisis – Clinical Confirmation & Referral for MH Services



4. Developing local Resource Guides



- Project Connect relies on Resource Guides to describe county services
 - Contact information
 - Staffing
 - Insurance accepted
 - Hours of operation
 - Disorders treated
 - Transportation access

5. Project Connect Training



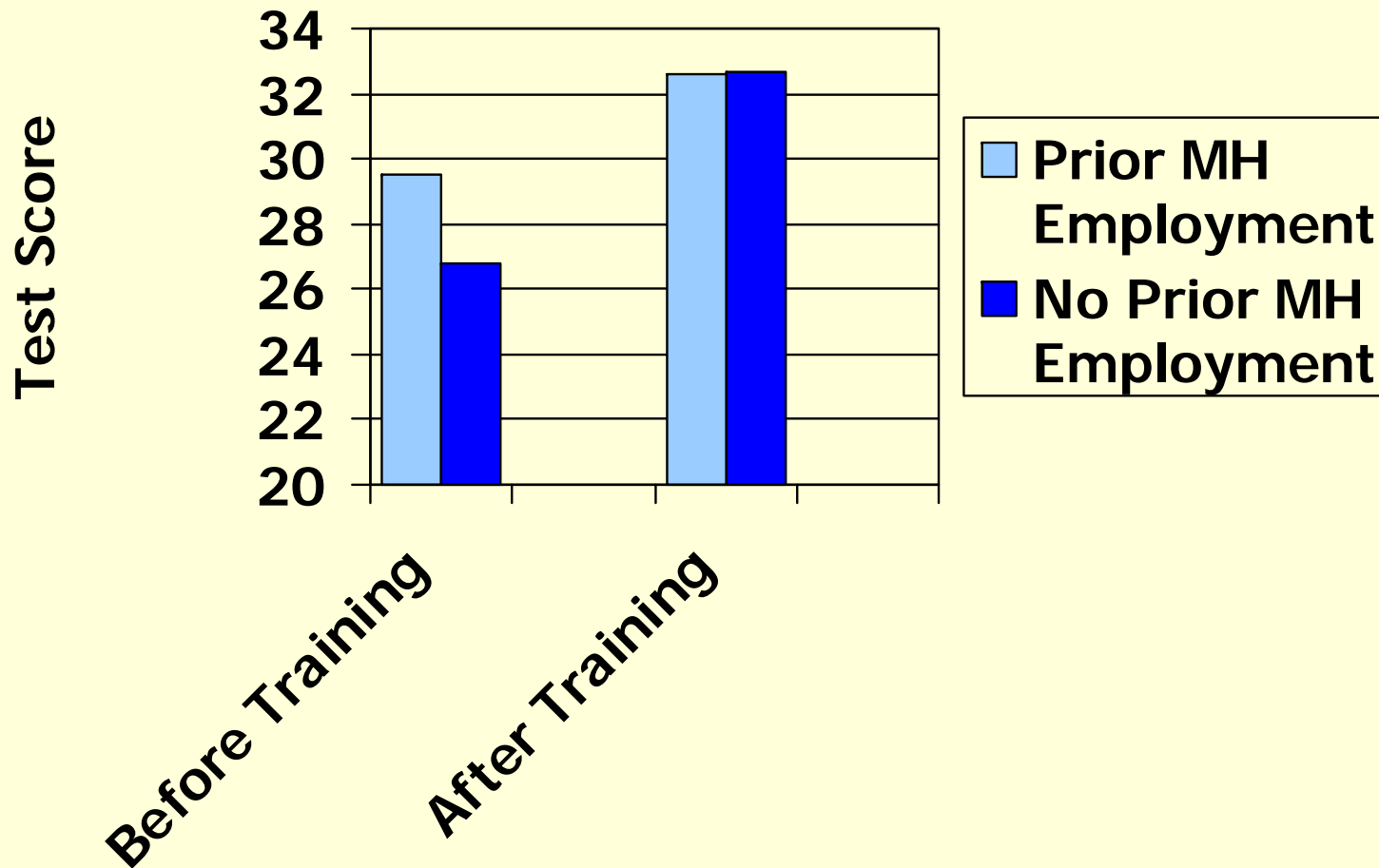
- Enhance probation officers' knowledge of:
 - Suicidal behavior and correlated risks
 - Specific mental health disorders
 - Evidence-based treatments for these disorders
 - Community mental health resources for youth
- Coach probation officers on how use
 - Effective screening techniques for identifying youth
 - Effective communication techniques for referring youth with mental health conditions
- Assist probation officers to implement new skills and knowledge into practice

88 PO's attended trainings



- Fall-winter 2006/2007
- The average PO was 41 years old
- Approximately 60% were female
- An average of 10.2 years in probation
- 39% had prior experience working in a MH setting
- 74% had no prior MH inservice training

All PO's learned, but those without prior MH experience learned significantly more



Overall, a 17.2% increase ($p < .001$)

Training increased overall perceived MH Competency significantly (4.3%)

- How well do you think you can.....
 - Identify an anxiety disorder
 - Explain to family the need for MH services
 - Act on a mental health problem
- 11 of 12 items increased, 6 significantly so
 - For example, there was a 10.8% increase in POs' perceived ability to identify an anxiety disorder
- 90% were either "Satisfied" or "Very Satisfied" with the training overall

Training Satisfaction



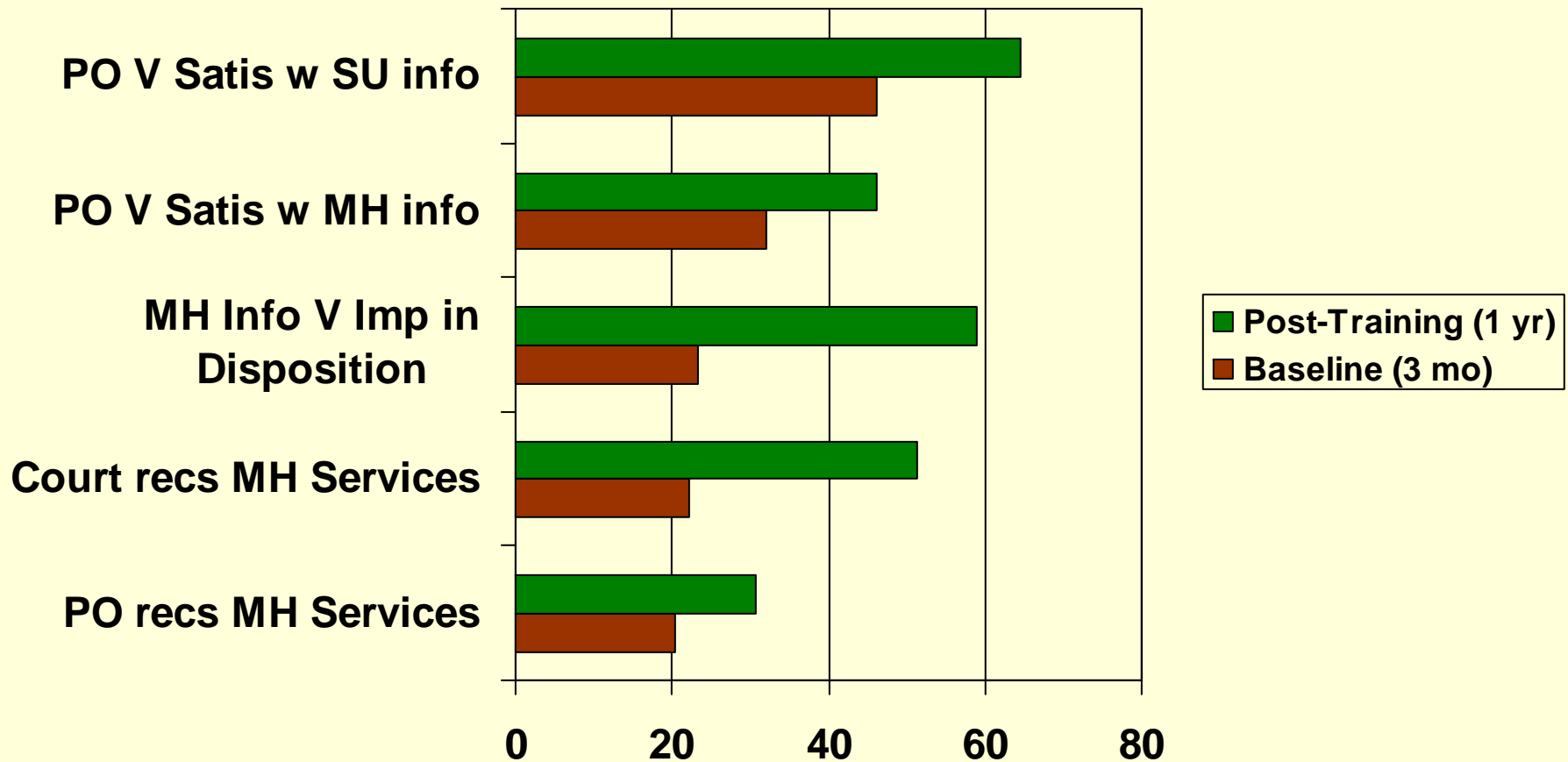
- 90% were either “Satisfied” or “Very Satisfied” with the training overall
- More than 90% “Agreed” or “Strongly Agreed” that the training was practical to their work and/or daily life
- 79% “Agreed” or “Strongly Agreed” that they were more ready to help with youth suicide prevention

Similar results in AL probations pilot



- 40 probation staff in Jefferson County, AL (12 hour, 2 day training)
- Training increased POs' mental health knowledge
- Training improved PO Attitudes about their MH competency
- Favorably evaluated MH curriculum
- Felt that training was likely to positively impact AL POs' relationship with youths

AL training alters recommendations, saliency and satisfaction (N=866 youths)



Conclusions



- There is a high rate of mental health concerns at each level of juvenile justice processing
- Problems are measurable and addressable at intake
- Targeted gatekeeper training increases probation practices that promote access to mental health services
- A public health model can be applied to mental health issues across diverse juvenile justice settings
- Failure to do so consistently results in **under-**identification of the burden of mental health need and suicide risk