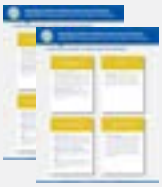
Keeping Kids in School and Out of Court

Supporting the Mental Health of Youth in Juvenile Court

Up to 80% of youth in foster care and 70% of youth who touch the juvenile justice system have significant mental health issues that are the result of both biological and environmental factors including exposure to trauma, violence, stress, and separation. The juvenile court can play an important role in addressing the need for care and supporting good mental health outcomes for youth.

This series of seven bench cards and linked Resource Guide provide quick and easy-to-reference information on key topics.

1. **Overarching Principles to Support Good Mental Health**



2. **Courtroom Practice Tips**

3. **Gathering Information, Identifying Needs**

4. **Community-Based Mental Health: Services and Funding Options**

5. **Considerations to Support Good Mental Health in Specific Placements: STRTP, Out of County, Juvenile Facility**

6. **Placement Transitions: Things to Consider to Support Good Mental Health**

7. **Important Ages: Is the youth turning age 3, 5, 12, 14, 16, 18, or 21?**

Resource Guide: Links to Key Sections

Look for this symbol throughout for a quick link to relevant additional information in the Resource Guide.

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For additional copies of the Resource Guide and bench cards, please go to:
https://www.courts.ca.gov/KKIS.htm

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1. Overarching Principles to Support Good Mental Health

Youth Engagement

"Kids just wanna have fun." Any successful treatment plan should include opportunities for normal developmentally appropriate activities, including recreation and relaxation. The team should know what the youth enjoys doing and create opportunities for that to happen.

Elevate the youth's voice. A youth's buy-in is essential to success in treatment. When possible, ask the youth about wants, needs, concerns, and goals.

Privacy

Words can hurt. Mental health issues carry heavy stigma. Discussing a youth's mental health symptoms in open court can increase shame and stigmatization. Do so with empathy and without disclosing more than necessary.

Process and Patience

Focus on the wins. Repeated criticism can be especially destructive to a youth struggling with mental health issues. If many things are going wrong, focus on one to three goals at a time and highlight successes—even small ones.

Relapse is often a part of healing. Expect back steps as a part of a larger arc of recovery—especially during any transition or major life event.

Patience. Even with excellent services in place, healing can take time. Remember to have patience when a youth doesn't demonstrate immediate progress.

Identify Your Experts

Know your experts. You do not need to become a mental health expert, but know who the experts are in the community. Expertise is not based solely on education and training, but also on how well a particular support person knows the youth. Parents should generally be considered experts on their children, and youth should be considered an expert on themselves.

1. Overarching Principles to Support Good Mental Health, cont.

Standard of Care: Home-like setting with services tailored to meet needs

Home is where the healing is. Home-like settings are more likely to create a sense of stability and safety for the youth and promote healing and therapeutic engagement. A youth should not have to move to have their mental health needs met. A removal itself can be traumatic and even the best congregate care can exacerbate problems. Wherever possible, youth should be wrapped with services that follow them and that are in home-like settings.

Least Restrictive Environment Standard. The placing agency has a responsibility to place youth in the least restrictive environment and identify and connect youth to services for which they may be eligible. Before a placement change, consider whether different or additional supports could stabilize the current placement. 16

Standard of Care: Multidisciplinary Collaboration and Trusted Adults

Teamwork makes the dream work. Inquire about who is a part of the young person's therapeutic, educational, social, and familial team as well as other supports they have in the community. The team's input and collaboration is essential, and together we make better decisions.

We all impact mental health. Our tendency is to think that mental health is the therapist's issue. But every decision that impacts the youth's life, from placement to education, impacts the youth's mental health. Acknowledging this responsibility helps us take more care in such decisions and plan for their impact on mental health. It also helps us remember that services alone may not be enough.

Teams are where multidisciplinary coordination happens. The Child and Family Team plays a key role recommending and coordinating services across systems and managing cases. Having the right people at that table is crucial. 29–30

Trauma and Culturally Informed Practice

Mental health is not just the presence or absence of illness. Every youth in the system has been through some level of trauma. Even youth not exhibiting symptoms of mental illness need us to make decisions with their mental health in mind.

Shift from "What's wrong with you?" to "What has happened to you?" "Tell us what's going on/What are you worried about?" Seeking to understand the underlying experience of the youth promotes empathy and decreases hostility.

If it's not culturally sensitive, it's not trauma-informed. Mental health services are not one-size-fits-all. Depending on the youth's family history, cultural background, previous exposure to mental health treatment, LGBTQ status, and other factors, certain therapies may be less effective or even harmful. We should always look for evidence-based treatment. 1–5

Youth Behavior

Look behind the curtain. Mental health diagnoses often present as defiance, irritability, avoidance, or delinquent behavior. Trauma also can change behavior and affect. Remain curious about the underlying causes of a troublesome behavior and seek guidance through use of assessments, the youth's team, and direct conversation with the youth and the youth's family.

Trauma or illness? Children are sometimes misdiagnosed with mental health disorders and inappropriately treated, when in fact the child is displaying behavioral adaptations related to past or current trauma episodes.

Survival or self-medication? Some behaviors stem from a youth's exploitation, victimization, or self-medication, or may serve a survival purpose.

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2. Courtroom Practices to Support Good Mental Health Outcomes

Welcoming Demeanor

- Make eye contact, listen actively, use a calm tone when speaking.
- Words matter so use language that avoids stigmatizing or re-triggering.
- When possible, avoid or explain inaccessible legal terminology.

Youth Engagement

- If age and developmentally appropriate, ask the youth for their perspective and whether others engaged the youth in the evaluation and planning process.
- Inquire about topics that are unrelated to the youth's case or services, such as hobbies or recent successes.
- Check in with the youth to see if they have any questions.

Privacy

- Do not discuss sensitive behavioral health information or diagnoses in open court. Instead, ask open questions and provide the youth with the opportunity to convey information to the court through other means. Consider sidebars for sensitive conversations.
- Be ready to order redactions if privileged or unauthorized information is in a court report. This is an important signal to a youth that you take their privacy seriously.
- Allow the youth time to speak privately with or ask questions of their attorney.

Youth Behavior

- Acknowledge the potentially triggering nature of the courtroom setting and encourage the youth to use available, appropriate supports during proceedings, such as asking questions of their attorney or stepping outside during a challenging part of a hearing.
- Recognize the signs of a youth in extreme distress. Is the youth exhibiting unusual behavior, such as hypervigilance, inappropriate smiling or laughter, extreme passivity, quickness to anger, or nonresponsiveness to simple questions?

Trusted Adults

- If age and developmentally appropriate, ask the youth if they have a trusted adult with whom they can confide.
- Consider appointing a CASA if the youth does not have a positive support system in place. CASA may be available for youth in the juvenile justice as well as the dependency system.

Concrete Process

- Focus on one to three goals at a time.
- Highlight successes, even small ones.
- Plan for relapse with robust transition discussions, including with caregivers.
- Transitions need careful planning.

Setting Treatment Related Conditions

- Identify the specific needs of the youth prior to setting treatment-related conditions of release.
- Maximize the potential for success by setting treatment conditions that are relevant, reasonable, and achievable in short time and that consider the youth's development and intellectual capacity.
- Does the youth have resources to satisfy conditions? Is treatment available?
- Does the youth understand conditions and what is expected? Trauma, stress, and illness may impact the youth's comprehension.
- Consider harm reduction rather than absolutism (e.g., if the youth is self-medicating with marijuana, support reduction rather than expecting complete elimination).

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3. Gathering Information, Identifying Needs

Good planning requires good information. The placing agency has the responsibility to provide certain information to the court. At every hearing, the court must consider and determine whether the youth's mental health needs are being met. The court may evaluate whether there is enough information to make such finding, inquire to obtain information, and make orders to ensure gaps in information are addressed.

Case Plan and Court Report:

Centering the Youth and Family

- What are the youth's strengths? Where does the youth feel safe? Valued? Respected?
- What perspectives were voiced by the youth?
- What perspectives do the parents and caregivers have?
- Has the youth recently experienced any big changes in the home or school environment that may have influenced assessments?
- Was the youth (age 14 and older) permitted to select at least two supporting adults to have present during the Child and Family Team (CFT)? Did they attend? A parent is not always the youth's choice of supportive adult.

6–7

Considering the Information Provided to the Court

- Was the health and education passport attached to the court report and does it include relevant mental health history?
- Does the court report identify mental health needs and recommend goals to meet those needs?
- Does the case plan demonstrate meaningful input from a CFT?
- Was there a Child and Adolescent Needs and Strengths (CANS) assessment?
- Did the CFT have the results of the CANS assessment?
- Did the CANS assessment suggest referral to the county Mental Health Plan is appropriate? If so, was referral made and documented?
- Has the agency documented the rationale for any inconsistencies between the case plan, recommended goals in the court report, and the CFT's recommendations?

8–9

Resource Guide References

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4. Community-Based Mental Health: Available Services and Funding Streams

Youths should be placed in the least restrictive setting possible. Providing appropriate and sufficient services often can ameliorate the need for more restrictive placements. Treatment to meet a youth's unique needs often requires coordinating a package of services available through different programs arranged, tailored, and monitored by a team.

Individualized, Tailored Services Coordinated through Team Decision Making

Coordination and monitoring of care often happens through the Child and Family Team or a Multidisciplinary Team and may use the Core Practice Model to guide work. 29–30

Resource Guide References

Crisis and locked placements and services:

Mobile Crisis Services	27
Voluntary Hospitalization	27
Involuntary Hospitalization	27–28
Juvenile Facilities	28

EPSDT and *Katie A.* Services:

Youth receiving SMHS may be entitled to an individualized, coordinated array of intensive home and community-based services to meet their mental health needs and allow them to meet youth's needs and stabilize a home placement. 18-19

Who may be a candidate for *Katie A.* specialty mental health services?

Includes but not limited to:

- In or at risk for STRTP, psychiatric health facility (PHF), or inpatient hospitalization, or had two or more placement changes due to unmet social-emotional needs
- One or more psychiatric hospitalizations in last 12 months
- Prescribed one or more antipsychotics or multiple psychotropic medications prescribed for mental health needs
- 0–5 years old and more than one mental health diagnosis, or 6–12 years old and more than two diagnoses
- Detained on a 601 or 602 petition primarily due to mental health needs
- Served by two or more agencies (such as special education, Regional Center, probation, child welfare)
- Other risk factors: homelessness, multiple emergency room visits for mental health needs, suicide attempts or history of self-injury, diagnosed drug overdose, bulimia or anorexia diagnoses, SSI recipient due to mental disorder
- See Medi-Cal Manual 3d ed. for more examples

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5. Considerations to Support Good Mental Health in Specific Placements

Is youth being...

Removed from parent custody in dependency?

- Consents for health and education services, including psychotropic medication. 31-32
- Parent access to confidential mental health information and authority to sign authorizations to release information. 33

Placed out of county?

- Are CFT and agency in agreement regarding placement?
- Does any party object? If yes, court must find youth's particular needs necessitate out-of-county placement. (Welf. & Inst. Code, § 361.2(h); Cal. Rules of Court, rule 5.651.)
- Has agency taken the appropriate steps to ensure continuity of and access to SMHS and educational services in that jurisdiction? If no, consider order. 21–22

Placed in an STRTP?

- Would additional services in the community, such as *Katie A.* services, help keep the youth in a home-like setting?
- Does case plan indicate youth has needs that necessitate this placement? Does it include plan to transition to less restrictive environment and time frame to do so?
- To ensure successful treatment, STRTPs are required upon referral or intake to complete several tasks. 21

Placed in or moving out of a juvenile facility?

- Medi-Cal is often suspended while in a juvenile facility. 28
- Youth are entitled to certain services from the facility while in placement. 28–30
- If the youth is being considered for foster care, has the probation officer commenced a CFT?

Resource Guide References

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6. Placement Transitions: Things to Consider to Support Good Mental Health

Transitions are always challenging, even if necessary or desired by the youth. Expect a regression of mental health symptoms as a matter of course as the youth will need to incorporate a new setting, routine, and feelings of loss or excitement. Avoid repeated or unnecessary transitions and acknowledge their impact. Address the following topics at each transition:

Process: Who is accountable to ensure continuity of care? Are the youth's belongings moving with the youth? If not, who is obtaining the belongings or responsible for securing essential items?

Funding for Services: If the youth is returning home to a parent with private insurance, ensure that this is addressed as part of the transition planning to prevent disconnect in services. If a youth is moving to another county, ensure continuous Medi-Cal coverage and service delivery are part of transition planning.

Mental Health Services: Will providers be changing? Was there a warm handoff between providers? Has there been an exchange of information to the new providers? Has a schedule and transportation been established for services? Are the new services comparable in quality to the previous services? Are any additional services or assessments required?

Psychotropic Medication: If the youth is currently on any medications, has a supply of medication traveled with the youth to ensure no interruption in the regimen? Does the youth and/or caregiver know where to access the next prescription? Does the caregiver have access to the necessary forms establishing the medication administration schedule?

Familial Connections: Will there be a change in visitation with family, friends, or other supports? Has transportation been arranged for visits? Do scheduled visits conflict with mental health services, recreational activities, school, or other essential activities?

School: Can the youth continue attending the same school? Has transportation been arranged? If the youth is changing schools and is receiving services under an IEP or 504 plan, have those been initiated at the new school?

Recreational Activities: Are the youth's interests and hobbies available in the new placement? Can activities, sports, or clubs from the previous placement continue at the new placement?

Transition from Psychiatric Facilities: Are recommendations from the psychiatric facility incorporated into ongoing services? Are providers, family members, and other supports encouraged to visit the youth in the facility to maintain support? Are medications changing as a result of a new medication evaluation?

Crisis Response: Does the caregiver have access to respite services? Are mobile response services available for the youth? Does the team have a plan to address escalation or crises?

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7. Considerations at Different Ages

Age 0–3

- Every youth should be assessed for delays in cognitive ability, motor skills, vision, hearing, speech, language, and social/emotional development.
- For all youth 0–3, the court report must state if the youth may be eligible for or already is receiving these services. 12

Age 3–12

- Is there any indication of disability or delays that may impact the youth's learning? If yes, the youth may qualify for services from the school district.
- For all youth 3 and older, the court report must state if the youth may be eligible for or already is receiving these services. 12

Age 12 and older

- Youth must be given opportunity to review, sign, and receive copy of case plan. 7
- Youth may and sometimes must consent for their own mental health and substance use services in some cases.
- Medical confidentiality rights to authorize or limit release of substance abuse and outpatient mental health treatment information transfer to youth.
- Rights to claim or waive psychotherapist-patient privilege are held by dependent youth if competent. 33–37

Age 14–15

- Case plan must be developed in consultation with youth. 6
- Case plan must include a written description of the programs and services that will help the youth, consistent with the youth's best interests, to prepare for the transition from foster care to successful adulthood. 6
- Questions to consider regarding transitioning to adulthood: Does the youth understand their medical condition, the services being provided and why, and how to access services in the community? Does the youth know how to communicate health concerns to a provider?

Age 16.5–17

- County must screen every youth in foster care, including youth in probation custody, at some point between 16.5 and 17.5 years of age for eligibility for Supplemental Security Income (SSI) benefits. (Welf. & Inst. Code, § 13757.)
- County must submit application for SSI on behalf of youth who screens as likely to be eligible for federal SSI. To the extent possible, the application must be timed to allow for a determination of eligibility by the Social Security Administration prior to the youth's emancipation from care.
- At age 16, the case plan must document whether there is a pending application for SSI or SIJS. 6

Age 18–21

- At adulthood, most young people consent to their own care, control release of health information, and may claim or waive evidentiary privileges. 33–37
- Questions regardin competency to direct legal counsel or make medical decisions? If the court finds a nonminor dependent not competent to direct counsel, the court must appoint a guardian ad litem. Questions regarding capacity to make medical or other legal decisions and whether there is a need for a conservatorship go to Probate. 26–27
- Medi-Cal eligibility. Some programs are available until age 21, and some until age 26. Is the youth enrolled? 17
- The youth may be eligible for extended foster care under category 5. 25–26

  Questions to consider regarding transition to adulthood: Does the youth have a copy of, or know how to access, their own medical history and record? Does the youth have a copy of their insurance information and identification documents? Does the youth know where to go for medical and mental health services?