

The Erie County Screening & Assessment Service Evaluation



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Amy C. Eisert, M.S.
Senior Research Analyst

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OVERVIEW

Over the past decade, there has been increasing documentation of the number of juveniles involved in the juvenile justice system with mental health and co-occurring substance abuse disorders. Otto et al. (1994) found that rates of mental disorders in youth involved in the justice system were substantially higher than those rates for the general population of youth, estimated at 9-13 percent (Friedman et al., 1996). Professionals suggest that youth who are seriously emotionally disturbed (SED) be diverted from the juvenile justice system; however, a lack of appropriate screening and assessment instruments has prevented diversion and proper treatment planning of these youth. And once identified, shelters and detention centers may not be equipped to provide the necessary services to effectively address the treatment needs of these youth.

In Erie County, the Edmund L. Thomas Detention Center is the primary provider of detention and shelter service for juveniles. On average each year, the Edmund L. Thomas Detention Center services between 425 and 430 youth, and the shelter services roughly 80 juveniles. Prior to 2003, the detention center was utilizing two screening tools: The Mercyhurst Level Security Screening Instrument (MLSSI) and the Massachusetts Youth Screening Instrument-2 (MAYSI-2).

The MLSSI evolved out of concerns related to overcrowding and is a screening instrument used to gauge the security risk of detained youth in order to assist in identifying youth eligible for outsource to staff secure facilities. The screening requires probation officers to identify any knowledge of drug and alcohol and/or mental health issues of each youth; however, the instrument is not an assessment tool, and only takes into consideration basic existing knowledge of the probation officer.

The MAYSI-2 is a self-report screening instrument and is administered to each juvenile within 24 to 48 hours of being detained. The screening is a computerized questionnaire consisting of 52 “yes” or “no” questions. The MAYSI-2 results in a score that can identify “caution” or “warning” scores in the following areas: anger/irritability, depression/anxiety, substance abuse, somatic complaints, suicidal ideation, thought disturbances, and traumatic experiences. It also provides a total score to reflect the youth's overall level of distress at that point in time. The MAYSI-2 had been utilized by detention primarily to identify suicidal concerns of any detained youth.

Neither screening instrument was sufficient in identifying the extent of the detainee's drug and alcohol and/or mental health issues, or the level and type of treatment those issues require. In addition, none of the youth admitted to any of the county's shelters through either the juvenile justice or child welfare systems were being assessed for any mental health or drug and alcohol concerns. Lack of appropriate assessment was believed to contribute to inappropriate treatment of detainees, which further impacted the number of juveniles being placed and the type of placement they received, the number of failure to adjust placements, the recidivism rates of juvenile offenders, and length of stay in detention and shelter.

In 2003, Erie County, in addition to Bucks, Chester, and Allegheny Counties, was selected to participate in the state's Screening and Assessment Project. It was Erie County's expectation that this service would enhance treatment planning for youth leading to increased effectiveness of the original placement and less need to utilize additional placements for mentally ill or substance abusing youth.

With the MAYSI-2 screening already in place, the new service looked to build upon the strengths of the existing system. The MAYSI-2 screenings were expanded to include not only all detention youth, but also all Erie County youth entering the Edmund L. Thomas Shelter, Perseus House Shelter, and Hermitage House Shelter. Any youth scoring a 27 or above on the MAYSI-2 was to be referred for assessment to a Level of Care Coordinator (LOC), an assessor hired through the Erie County Wraparound Office. The LOCs were trained in the CALOCUS (Child Adolescent Level of Care Utilization System), ASAM (American Society of Addiction Medicine) instrument, and the ICA (Integrated Child Assessment) developed by Dr. Hodas, the Pennsylvania Child Psychiatric Consultant for the Bureau of Children's Services in the Office of Mental Health, Pennsylvania Department of Public Welfare.

Once a youth was identified through the MAYSI screening, detention or shelter staff were to notify LOCs that an assessment was needed. Within 48 hours, an LOC was to meet with the youth, and family if possible, obtain consent for the service and conduct the ICA. ASAMs were conducted as warranted. Utilizing the information from those assessment tools, the LOC would score the youth utilizing the CALOCUS to determine level of care. Depending upon need, the LOCs could refer for further psychological or psychiatric evaluation. Once the assessment was completed, the LOCs were to provide their information and recommendations to the Child and Family Team and Resource Management Team in addition to the individual caseworker and/or juvenile probation officer. The caseworker and/or juvenile probation officer would then utilize the information provided in LOC's report for disposition for the courts consideration. Information obtained during the screening and assessment service was specifically developed for treatment planning and placement recommendations and was never utilized during the adjudication phase for participating youth.



PARTICIPANT DATA SUMMARY

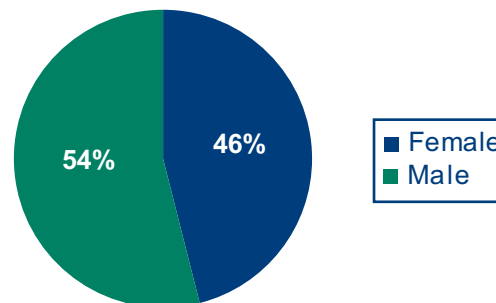
From December 1, 2003 to March 21, 2005, 164 juveniles were referred to the Screening and Assessment Service, 127 through juvenile probation and 37 through child welfare. Of those 164 youth, 114 agreed to participate in further assessment, 82 being from juvenile probation and 32 from child welfare. Of those 114 youth, 80 participants consented to both the assessment and research component of the Screening and Assessment Project. Of those 80 youth, only one youth was entered into the project twice due to being detained over three months after initial project involvement. Of those consenting to the research component of the project, 57 participants were initially detained through the juvenile probation department, and 23 were initially detained through the child welfare system.

Demographics

Participants ages ranged from 11 to 17 years, the median and mode age being 15. Only 4 participants were under the age of 13. In order to participate in the assessment project and research component, youth and their guardians had to consent to both the assessment and the project. It is unclear if the under representation of youth under the age of 13 is due to an inability to obtain parental consent or whether younger youth were not identified through the initial MAYSI-2 screening process. Of the 80 participants, 46% were female and 54% were male (see Figure 1).

Figure 1.

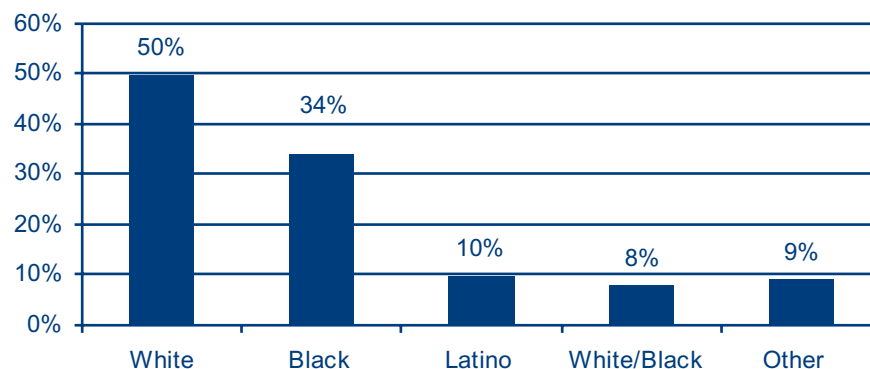
Participant Gender



The breakdown of participant race was as follows: 50% white; 34% black; 10% Latino; 8% white/black; 9% other (see Figure 2).

Figure 2.

Participant Race



MAYSI-2 scores ranged from zero to 49, the higher the score indicating a need for further assessment. Youth scoring above 27 were identified as in need of further assessment. The median and the mode scores for participants were 28. Twenty participants were in the control group (score of 27 or below) and 60 participants were in the experimental group (scores above 27). Sixty-nine percent of all participants were identified as having had previous mental health services.

Fifty-six percent of participants had criminal charges. Of those with criminal charges, the most common primary charges were failure to comply or incorrigibility (14%). The second most common primary charge was simple assault (13%). The most serious primary charges of participants included arson, robbery, and aggravated assault. Of those youth detained in shelter for reasons other than criminal charges, child's mental health was the most common reason (68%), followed by truancy (45%), lack of supervision (36%), and abandonment/dependency (27%).



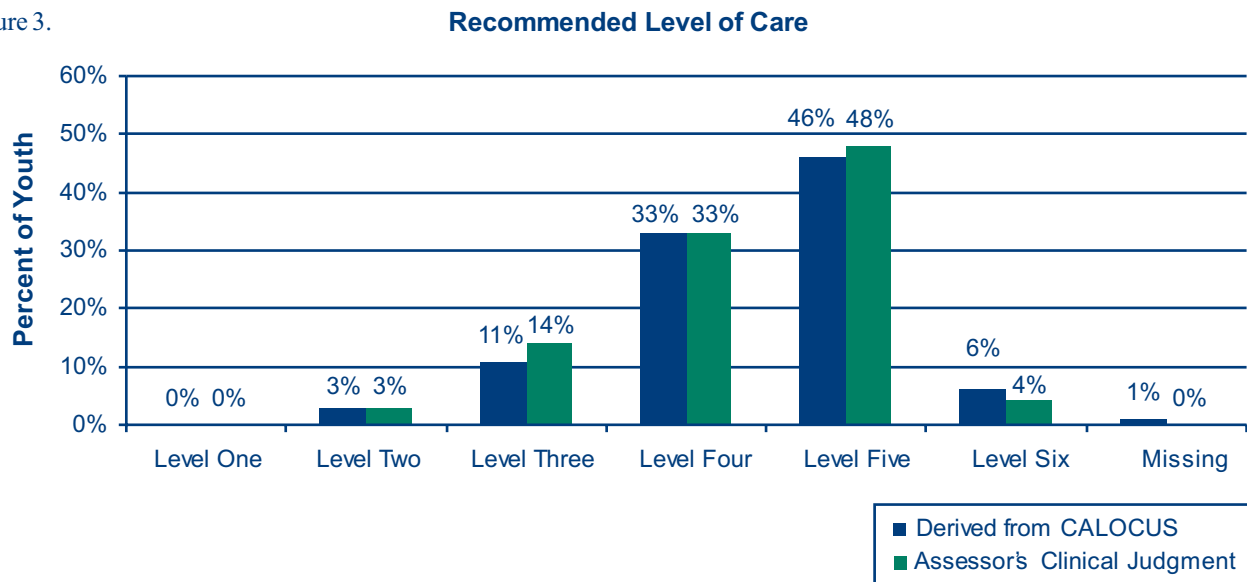
Of the 80 participants, 58% had not been detained in detention and/or shelter previously. Of those youth that had been previously detained, 32% had been detained one time, 29% had been detained two times, 21% had been detained three times, 15% had been detained five times, and 3% had been detained eight times.

Assessment

The mode and median level of care derived for participants from the CALOCUS was Level Five, nonsecure 24 hour psychiatric monitoring, (46%). Thirty-three percent of participants scored in the Level Four, intensive integrated service without 24 hour psychiatric monitoring. Two participants (3%) scored in the range of Level Two, outpatient services, 11% of participants scored in the range for Level Three, intensive outpatient services, and 6% of participants scored in the range for Level Six, secure 24 hour services with psychiatric monitoring.

The assessor's clinical judgment mirrored the levels identified strictly from the CALOCUS score (see Figure 3). The median and mode level of care derived from the assessor's clinical judgment was Level Five, nonsecure 24 hour psychiatric monitoring (48%). The assessor recommended Level Four, intensive integrated service without 24 hour psychiatric monitoring for 33% of participants, Level Three, intensive outpatient services for 14%, Level Six, secure 24 hour services with psychiatric monitoring for 4%, and Level Two, outpatient services for 3%.

Figure 3.



Evaluation

Of the participants, 59% had either a psychological evaluation and/or psychiatric evaluation, or both conducted. Psychological evaluations less than 3 months old were utilized and psychiatric evaluations less than 6 months old were utilized unless a youth warranted a more recent evaluation. The evaluator's most common recommendation was for Level Five, nonsecure 24 hour psychiatric services with psychiatric monitoring (39%), followed by Level Three, intensive outpatient services (26%), Level Four, intensive integrated service without 24 hour psychiatric monitoring (21%), Level Two, outpatient services (9%), and Level Six, secure 24 hour services with psychiatric monitoring (4%).

Sixty-nine percent of participants required an ASAM as determined by the LOCs, and of those youth requiring an ASAM, the most frequent recommendation through the instrument was for outpatient treatment (38%). Of those youth who received a psychiatric or psychological evaluation, the evaluator indicated a substance abuse problem for 26% of those participants. Of those participants in whom a substance abuse problem was noted during the psychological or psychiatric evaluation, 46% were recommended by the evaluator to seek outpatient treatment.

Of participant information provided from the ICA, only 5% were reported as not being on any medication. In 6% of participants, a new medication was added after the psychological/psychiatric evaluation, and none of the participants who were currently on medication had medication eliminated.



Integrated Service Plan Team Meetings

An integrated service plan team (ISPT) meeting was held for over one-third of participants (67%), the most frequent recommendation being Level Four, nonsecure, 24 hour services, followed by Level Three, intensive outpatient (30%) and Level One, basic services (4%). There was a slightly moderate relationship between the LOC's recommended level of care and that of the ISPT ($r=.498, p<.001$).

There were only 20 cases where an ISPT and an evaluation were recorded and there was a moderate relationship between the recommended level of care by the ISPT and that of the evaluator ($r=.50, p<.001$).

Court Recommendations

In all cases, the caseworkers and probation officers were reported to have provided a mental health recommendation to the judge. In 99% of cases, this was done in a written document; however, in one case, this was done through testimony in court.

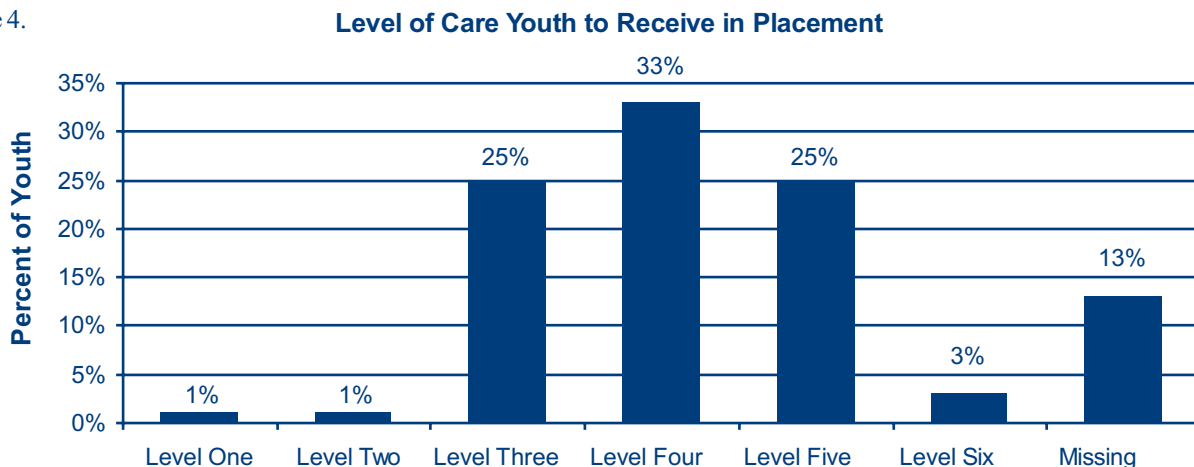
The caseworker and probation officer placement recommendations for participants were RTF (residential treatment facility) (30%), return to family/send home (19%), residential center (16%), group home (15%), foster care (5%), youth forestry camp (3%), youth development center (3%), and drug and alcohol facility (3%). Recommendations were missing for 5% of participants.

Sixty-three percent of participants were adjudicated delinquent, and 34% were adjudicated dependent. The most frequent primary charge for which participants were adjudicated delinquent was disorderly conduct (12%), followed by simple assault (6%) and criminal conspiracy (6%).

The dispositions imposed on participants by the judges varied; however, they were consistent with the recommendations made by juvenile probation officers and caseworkers ($r=.78, p<.001$). Twenty-nine percent were to an RTF, 20% were sent home, 15% to a group home, 13% to a residential center, 6% to a youth development center, 4% to foster care, 4% to a youth forestry camp, and 3% to a drug/alcohol facility. The dispositions of 8% of participants were missing.

The breakdown of services participants were to receive in placements imposed by the judges were as follows: Level Four, intensive integrated service without 24 hour psychiatric monitoring (33%), Level Three, intensive outpatient services (25%), Level Five, nonsecure 24 hour services without psychiatric monitoring (25%), Level 6, secure 24 hour services with psychiatric monitoring (3%), Level One, recovery maintenance and health management (1%), and Level Two, outpatient services (1%) (see Figure 4).

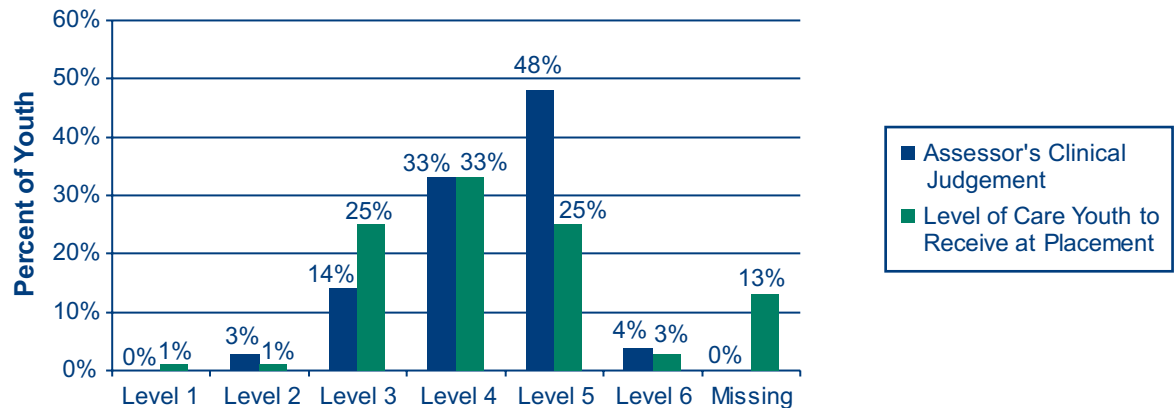
Figure 4.



When comparing the LOC's clinical level of care recommendations to that of the court dispositions, the assessors were more likely to identify youth needing a higher level of care, recommending Level Five in 48% of cases; whereas the levels of care youth were to receive in placement were slightly lower (see Figure 5).



Figure 5. Comparison of Level of Care Recommendations and Disposition



Detention/Shelter Stay

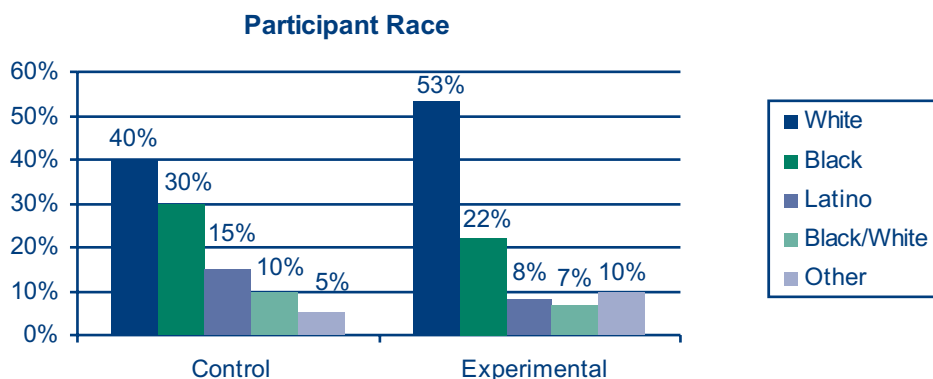
During their stay in detention/shelter, 18% of participants required emergency intervention as identified by the LOCs. Emergency intervention was defined as a situation with a youth where Crisis Services was contacted for consultation or assessment for inpatient admission. The median length of time between the detention hearing and assessment was 3 days. The median length of time for a new psychological evaluation was 11 days, and 22 days for a new psychiatric evaluation. The median length of time from entrance to detention/shelter to the dispositional hearing was 28 days. The median length of stay for participants was 31 days; the mode length of stay was 24 days.

CONTROL VERSUS EXPERIMENTAL DATA COMPARISON

Control group participants were drawn from the detention center only, and referred at random from the detention staff member responsible for administering the MAYSI-2. MAYSI-2 scores were withheld from the LOCs, therefore, the LOCs were unaware of the identification of control participants being referred into the service. Twenty participants made up the control group and 60 made up the experimental group. MAYSI-2 scores of the control group ranged from zero to 27 and scores of the experimental group ranged from 28 to 49.

The mode age for both the control and experimental groups was 15. The median age for the control group was 14 to 15 and the median age for the experimental group was 15. The control group was identified as 40% white, 30% black, 15% latino, 10% black/white and 5% other. The experimental group was identified as 53% white, 22% black, 8% latino, 7% black/white, and 10% other (see Figure 6).

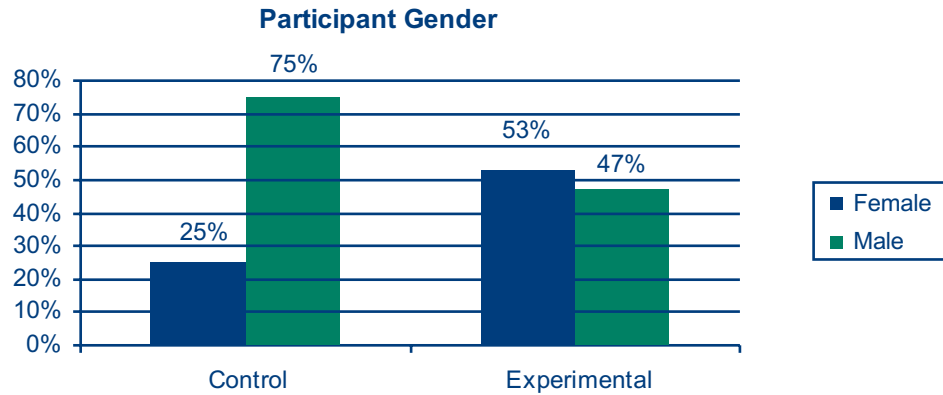
Figure 6.



Gender was disproportionate between the control and experimental groups (see Figure 7). Males accounted for 75% of the experimental group but less than half (47%) of the control group; however, when controlling for gender, there were no statistically significant differences between the groups related to prior mental health history, assessor's clinical judgment of level of care needed, youth requiring an ASAM assessment, disposition imposed by the judge or the level of care youth to receive in dispositional placement.

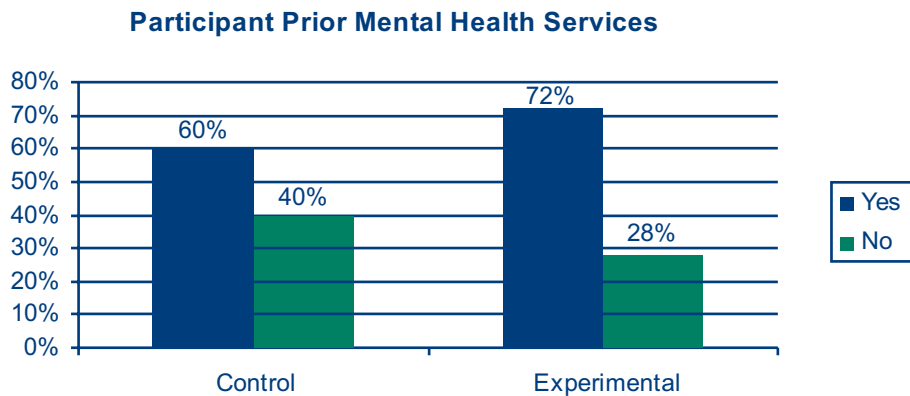


Figure 7.



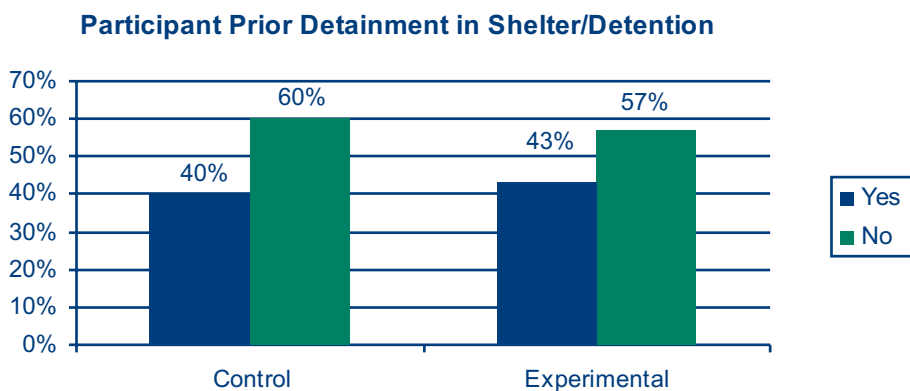
Prior mental health services of participants in the experimental group (72%) were slightly higher than the control group (60%) (see Figure 8).

Figure 8.



There was no significant difference between groups regarding to whether or not the youth had a prior shelter/detention detention; however, youth from the experimental group were more likely to have been detained on more than one occasion (see Figure 9).

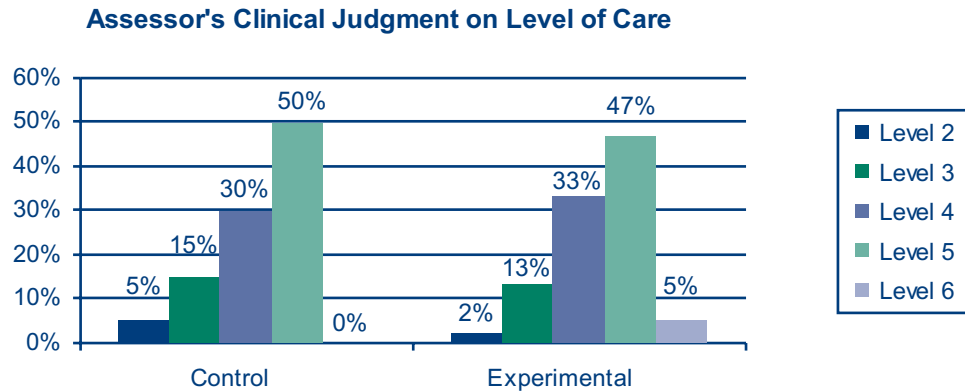
Figure 9.



There was no significant difference in level of care recommendations by the assessor between the control and experimental groups (see Figure 10). None of the youth from the control group were recommended to Level Six (secure 24 hour services with psychiatric monitoring); however 50% of youth in the control group were recommended to receive services at Level Five (nonsecure 24 hour psychiatric monitoring).

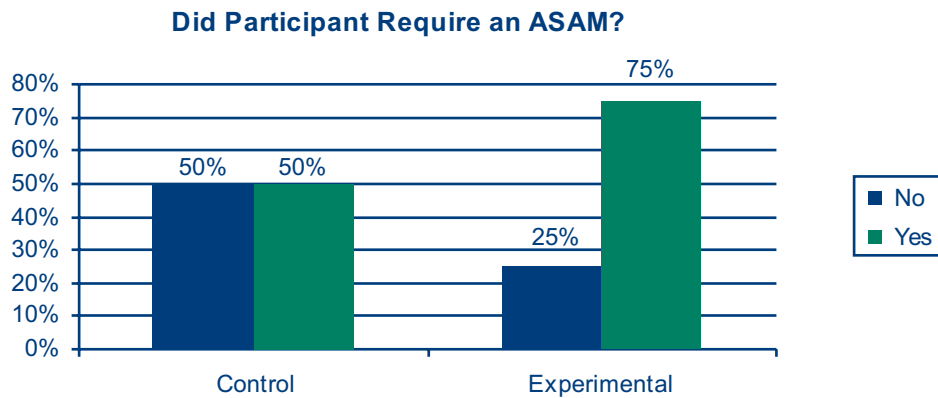


Figure 10.



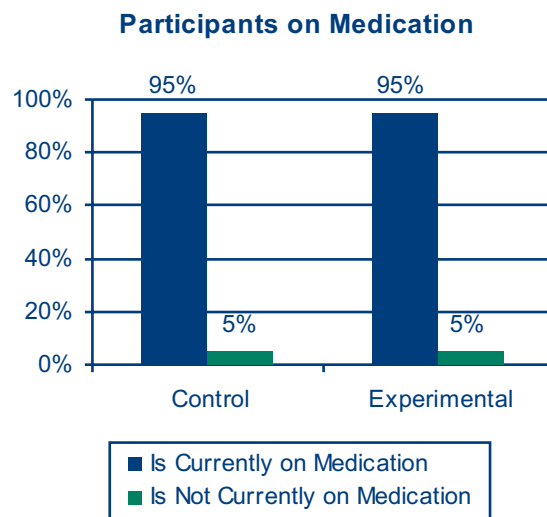
Seventy-five percent of participants in the experimental group required an ASAM, whereas only 50% of those youth in the control group required an ASAM (see Figure 11).

Figure 11.



Ninety-five percent of both the experimental and control group participants were taking psychotropic medication as reported on the ICA (see Figure 12).

Figure 12.

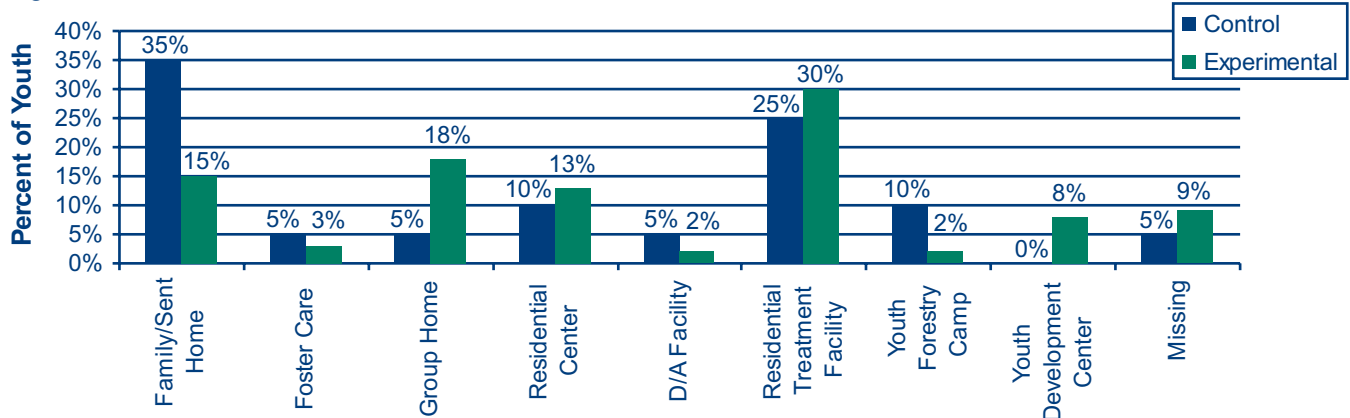


Regarding disposition, a higher percentage of youth in the control group were sent home (35%) than in the experimental group (15%); however, 25% of those in the control group were sent to residential treatment facilities, similar to the percentage of youth sent to residential treatment facilities in the experimental group (30%) (see Figure 13).



Figure 13.

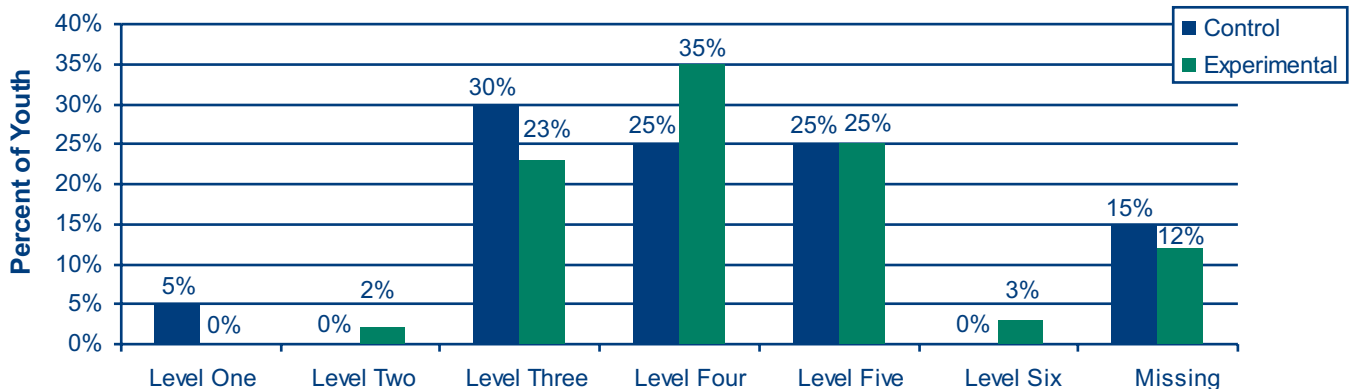
Comparison of Disposition Imposed by Judge



When comparing the level of care the youth were to receive at the dispositional placement, youth from the control group were slightly more likely to receive lower levels of care, 5% in Level One (recovery maintenance and health management) and 30% in Level Three (intensive outpatient services) (see Figure 14). Youth from the experimental group were more likely to receive levels of care in Level Four, (35%) and Level Six (3%); however, 25% of both the experimental and control participants were to receive care at Level Five (nonsecure 24 hour psychiatric monitoring). Youth in both the control and experimental groups were more likely to receive lower levels of care at disposition despite the LOCs' clinical judgments recommending higher levels of care.

Figure 14.

Comparison of Level of Care Youth to Receive in Placement



SERIOUS EMOTIONAL DISTURBANCE (SED)

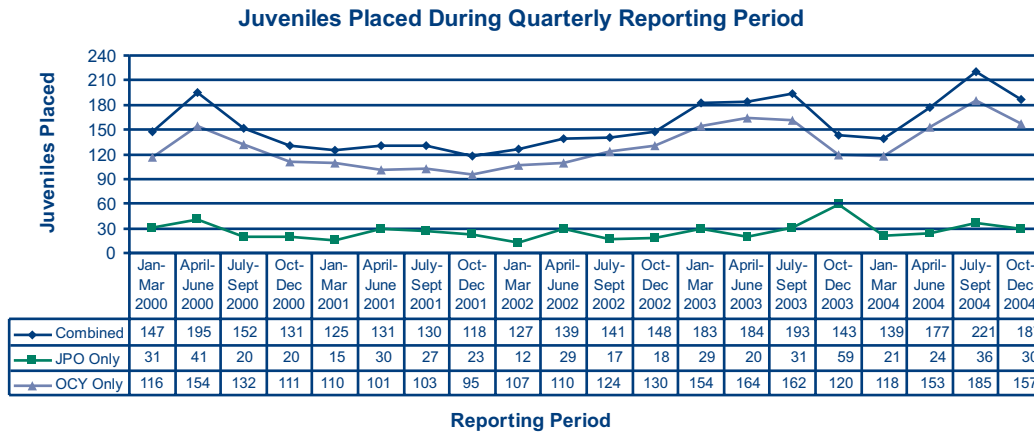
In an attempt to assess the project's success in screening out youth needing further evaluation for mental health services, 357 youth administered the MAYSI-2 at the Edmund L. Thomas Detention Center and Perseus House and Hermitage House Shelters from November 2003 through August 2004 were cross referenced through the Erie County Wrap Office to determine whether the youth had previously been identified as Seriously Emotionally Disturbed (SED). Of the 358 youth, 168 were identified as being SED (46%) at the time the MAYSI-2 was administered. Seventy-four of the 168 were referred into the project via the MAYSI-2 for further assessment (44%). Twenty-six percent of those youth who had already been identified through Wraparound as being SED were not identified as needing further assessment. Per the state's evaluation, only those youth receiving a MAYSI-2 score of 27 or above were to be referred for further assessment; however, due to the percentage of youth with SED that were not identified, revisiting the cut off scores of the MAYSI-2 flagging a youth for further assessment is warranted.

PLACEMENT TREND DATA

It is uncertain as to the correlation between the Screening and Assessment Service on placement rates. During the quarter prior to and during the implementation of the Screening and Assessment which formally began December 1, 2003, there was a slight decrease in overall OCY and juvenile probation placements followed by a steady increase (see Figure 15).

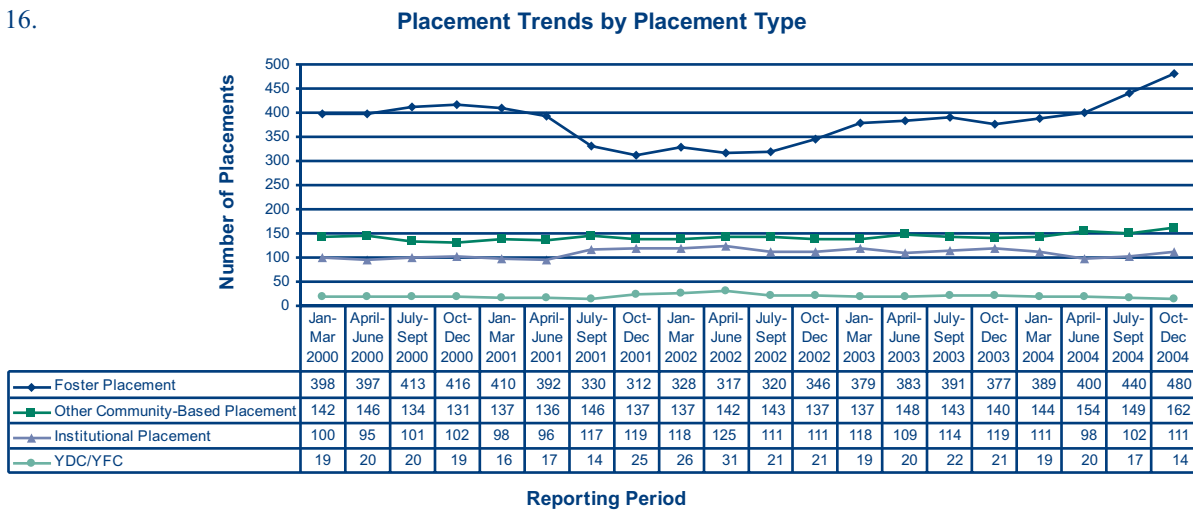


Figure 15.



When breaking down placements by type, foster care placements have risen while institutional placements have remained relatively stable (see Figure 16). There was a slight decrease in youth detention centers (YDCs) while there was a slight increase in other community-based placements, which would include residential treatment facilities (RTFs). Further analysis needs to be conducted in order to identify the longer term impact of the Screening and Assessment Service on placement rates.

Figure 16.



PROCESS EVALUATION

In addition to the outcome evaluation, a process evaluation was conducted to identify the barriers during implementation and the strengths of the project. Focus groups were conducted with juvenile probation officers, line staff and supervisors as well as with caseworkers and child welfare supervisors. In addition, focus groups were conducted with the resource management teams for both juvenile probation and child welfare.

During the focus groups, a number of strengths were identified. The screening and assessment service was identified as having provided a wealth of current information pertaining to the youth's background and clarified placement, treatment, and diagnostic histories reducing the leg work of gathering background data, saving case workers and probation officers time. Referral to the service not requiring any additional paperwork on the part of juvenile probation or child welfare was identified as a positive component to the project. Other strengths identified were: the assessment being family focused, providing current family issues, and even providing a physical description of the youth. The information provided by the service was identified as being helpful in treatment goal planning and assisting in psychological evaluations, identifying additional clinical needs of youth that could follow them to placement. The service was identified by some as being more helpful in the case of residential treatment facility (RTF) placements, assisting in completing the necessary paperwork for the state. The service was also identified as being more helpful with juveniles new to detention and shelter who are not as well known to the juvenile probation officers and caseworkers. The service was identified as being helpful in bringing into perspective the whole piece (behavior, mental health, family) especially in cases with newer workers or even older workers that are "in a rut". As reported by one focus group participant, the service helps rethink the case and consider it from a fresh perspective, for instance with youth that have had every service.



Training of the LOCs was identified as being an important component to the position. Juvenile probation officers agreed they would be more receptive to an individual who had law enforcement/probation/placement experience and could recognize the point of view of probation. They felt LOCs should receive training in accountability and BARJ principals to assist in that. In addition, caseworkers and supervisors identified the LOCs having child welfare experience as being a plus but that having an LOC who can relate to kids is the most important component. However, having the LOCs being a “neutral party”, not a caseworker or probation officer was identified as being a strength. This was reported to have removed emotions, helping to balance for a better decision. In addition, some kids might disclose things that they would not generally tell their caseworkers, but that they felt comfortable discussing with the LOCs. One participant identified that the service was helpful even if the LOC provided feedback with which the caseworker/probation officer did not agree. The information made the caseworker/probation officer rethink the case and consider all the options.

The participants further indicated that the project may be more useful if completed at intake as opposed to time of detainment in shelter/detention. In addition, focus group participants indicated a desire to see all first time shelter/detention intake assessed, not just screened. There was a desire by participants to have more information about the assessment tools utilized in the service to provide a better understanding of the assessment process and data gathering. Supplementing the MAYSI with the children's depression inventory was mentioned.

Some barriers to the service that were identified included concerns about how youth were identified through the project as needing assessment. Some focus group participants identified that detained youth who needed assessment were not being identified through the screening, especially younger kids. Others, however, identified that some youth were flagged through the screen as needing further assessment but the caseworkers/juvenile probation officers felt further assessment was unnecessary. In addition, strengthening communication between caseworkers and probation officers earlier on in the assessment process was identified as an area needing improvement. Having the LOCs contact the caseworkers and/or probation officers prior to assessing the youth was identified as important so that the LOCs can be made aware of any sensitive situations pertaining to the youth and family. Finally, providing a written report earlier on in the process was identified as most beneficial to caseworkers and probation officers.

RECOMMENDATIONS

One identified goal of the project was early identification and treatment of mental health and substance abuse issues of juveniles being detained in shelters and detention. Most of the youth, both in the experimental and control groups, had been previously identified as having mental health needs, and therefore implementation of a screening process earlier on in the juvenile justice and child welfare systems is warranted.

Similarities of mental health needs and treatment recommendations made of youth in the control and experimental groups in addition to feedback from the process evaluation suggest re-evaluating the cut off scores of the MAYI-2, possibly assessing need for further assessment on warning and caution scores as opposed to total score.

Additional evaluation specifically in the form of follow up with participants is needed to determine if the process was successful in improving identification of placement type and treatment needs of youth, in turn reducing recidivism, replacement rates, and failure to adjust rates.

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