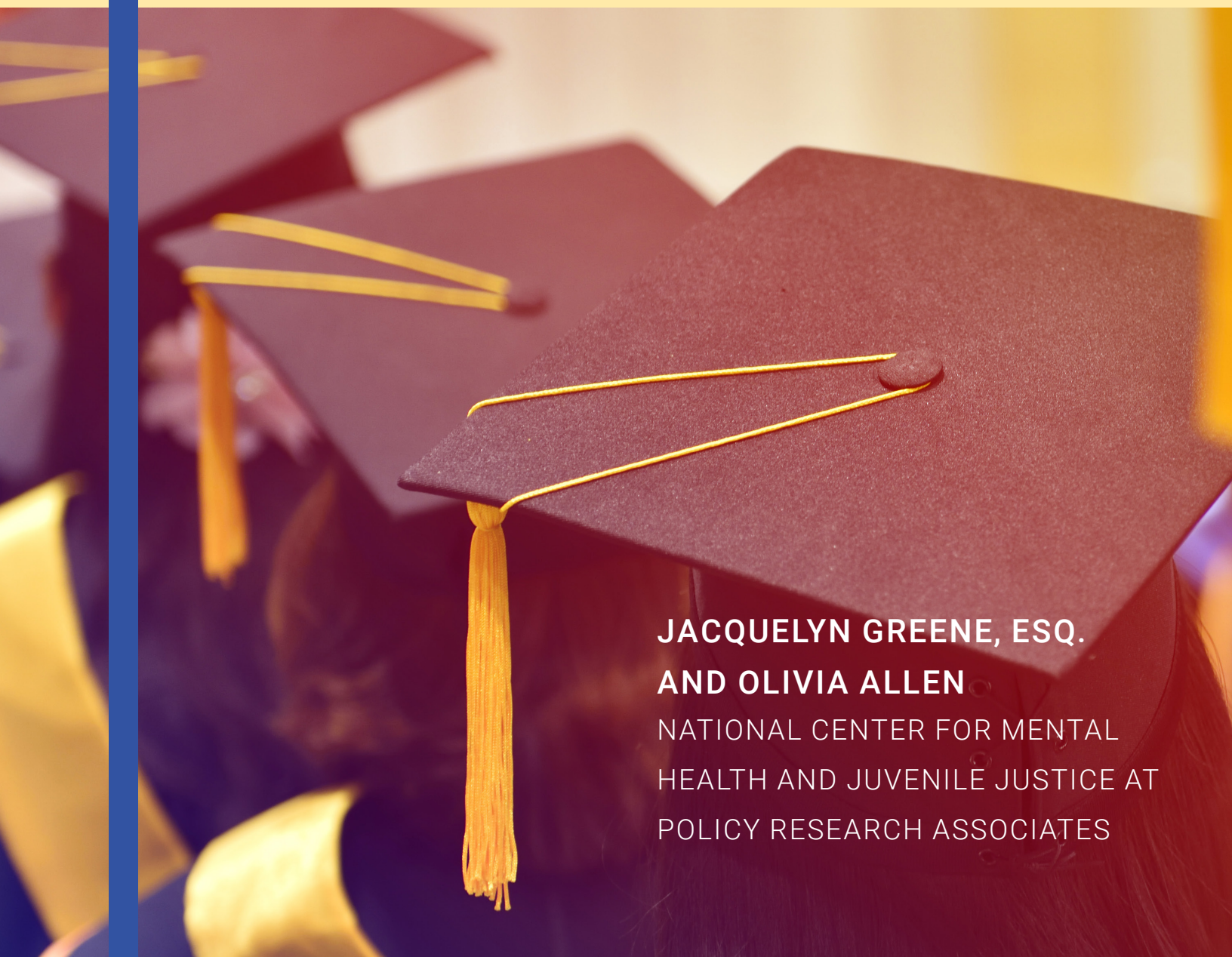
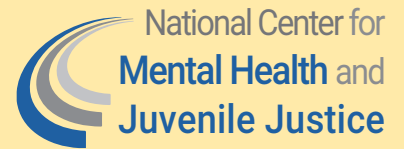
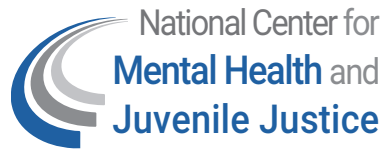


DISRUPTING SCHOOL-JUSTICE PATHWAYS FOR YOUTH WITH BEHAVIORAL HEALTH NEEDS



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The National Council of Juvenile and Family Court Judges® (NCJFCJ), an affiliate of the University of Nevada, Reno, provides cutting-edge training, wide-ranging technical assistance, and research to help the nation's courts, judges, and staff in their important work. Since its founding in 1937 by a group of judges dedicated to improving the effectiveness of the nation's juvenile courts, the NCJFCJ has pursued a mission to improve courts and systems practice and raise awareness of the core issues that touch the lives of many of our nation's children and families.

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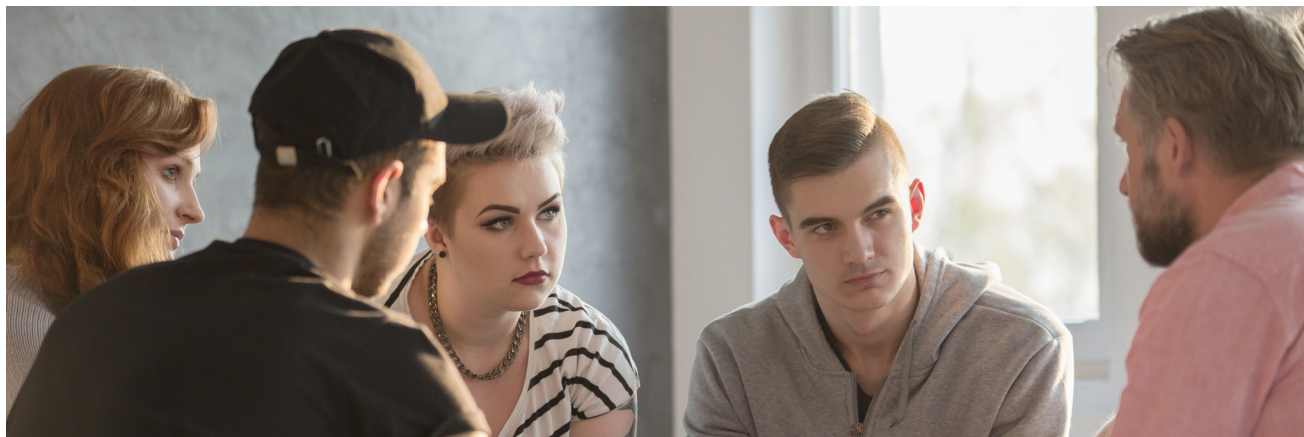
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Acknowledgements:

This Technical Assistance Brief is a publication of the National Council of Juvenile and Family Court Judges (NCJFCJ). The NCJFCJ wishes to acknowledge that this material is made possible by 2014-JZ-FX-K006 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice or the NCJFCJ.

Suggested Citation:

Greene, Esq., J. D., & Allen, O. W. (2017). *Disrupting School-Justice Pathways for Youth with Behavioral Health Needs*. National Council of Juvenile and Family Court Judges.



OVER THE PAST SEVERAL DECADES, the increasing use of zero-tolerance policies in schools, coupled with a trend toward the use of law enforcement to respond to a wide array of misbehavior inside schools, led to a dramatic increase in exclusionary discipline (suspension and expulsion) and school-based arrests. Examples of the use of arrest to respond to low-level school infractions highlight the proliferation of pathways from schools to justice system involvement. A 6-year-old kindergartener was handcuffed and arrested for throwing a temper tantrum in the classroom, (Campbell) youth as young as 11 have been arrested for participating in cafeteria food fights, (Saulny) and young people have been arrested for infractions as minor as doodling on a desk. (Monahan)

As the research discussed below indicates, youth with behavioral health needs (which include mental health conditions, substance use disorders, and experience of traumatic stress) are at increased risk of both exclusionary school discipline and school-based arrest. The work of the National Center for Mental Health and Juvenile Justice has focused on supporting states and localities in efforts to reduce that risk since coordinating the MacArthur Foundation's Models for Change Mental Health/Juvenile Justice Action Network from 2007 - 2011. During that time, the eight participating states identified school-based diversion from justice system involvement as a top priority to keep children and youth with behavioral health needs away from unnecessary juvenile justice system involvement.

The information in this technical assistance bulletin highlights the prevalence of the use of exclusionary school discipline and arrest with youth who face behavioral health challenges and provides a road map for creating a system that instead offers youth connection to community-based services to address their behavioral health needs. That road map was developed by



systems leaders in the field who successfully operationalized a “School Responder Model” (SRM), initially developed as part of Models for Change. SRMs have been shown to reduce the use of arrest in schools and increase access to behavioral health services for young people.

This technical assistance bulletin is intended to provide an overview of the steps necessary for implementing an SRM. It may be used to introduce colleagues or stakeholders to the history and core components of an SRM, may be used as supporting evidence in efforts to persuade policymakers to adapt similar policies, or may be used as a road map for beginning to stand up an initiative modeled after the SRM. Creation of this pathway to community-based services in lieu of a pathway to the juvenile justice system holds promise for improved opportunities for youth and additional resources for schools to address behavioral health needs without requiring a law enforcement response to school infractions that pose minimal threat to public safety.

SCHOOL-JUSTICE PATHWAYS AND BEHAVIORAL HEALTH NEEDS

The growth of zero-tolerance school discipline policies throughout the 1990s brought a new era of strict and mandatory disciplinary responses for a wide range of school misbehavior. The federal Gun Free Schools Act of 1994 required any school in receipt of federal education funding to expel, for at least 1 year, any student who brought a firearm to school. (Kang-Brown, Trone and Fratello) Many schools adopted zero-tolerance policies that went well beyond weapons and often included lower-level infractions such as smoking and school disruption. (Wagner, Kutash and Duchnowski) Just two years after the Gun Free Schools Act, 79% of schools reported having zero-tolerance policies including at least violence, weapons, alcohol, drugs, and tobacco. (National Center for Education Statistics, Bureau of Justice Statistics) At the same time, the presence of security guards and school-based law enforcement rose dramatically across the country. In fact, the number of full-time law enforcement and security guards in public high schools tripled between the 1996-97 school year and the 2007-08 school year. (Kang-Brown, Trone and Fratello)

This shift to rigid policies of school exclusion for a wide range of misbehavior, combined with the increased use of a justice-focused response, has had a disparate impact on young people with behavioral health needs. The Office for Civil Rights at the U.S. Department of Education found that students with disabilities (defined as students with Individualized Education Plans) are twice as likely to experience an out-of-school suspension as students

FIGURE 1: MIDDLE AND ELEMENTARY SCHOOL STUDENTS SUBJECT TO SUSPENSION OR EXPULSION

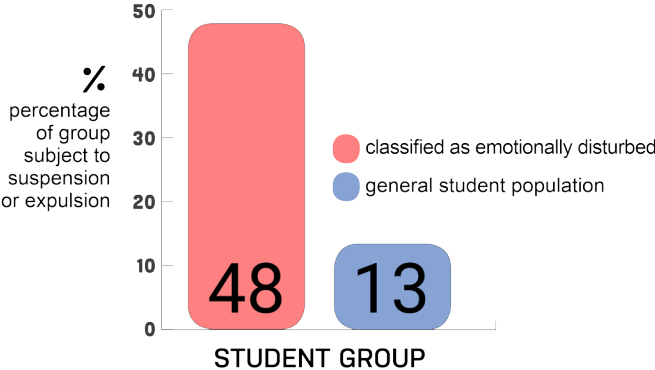
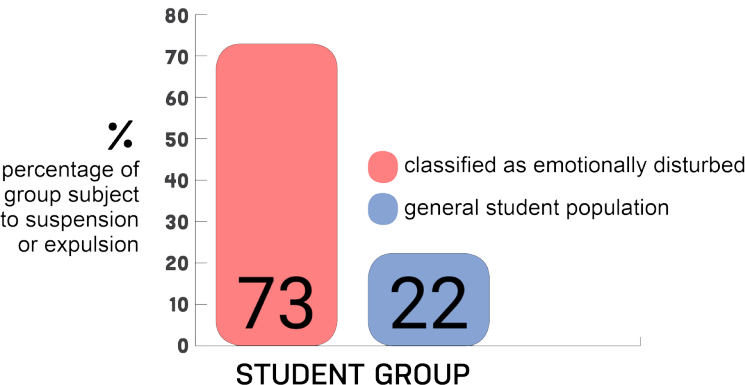


FIGURE 2: SECONDARY SCHOOL STUDENTS SUBJECT TO SUSPENSION OR EXPULSION

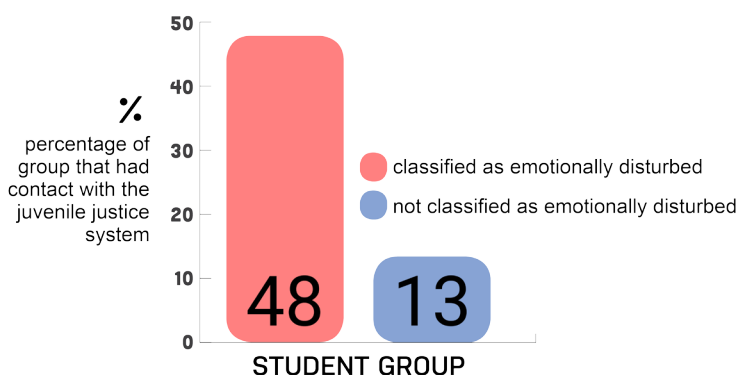


without disabilities. The use of suspension and expulsion are often the first step into the pathway to the juvenile justice system.

This disparity is especially pronounced for youth who are classified with a disability as a result of emotional disturbance (ED), indicating a behavioral health need. Analysis of a nationally representative database found that 48% of elementary and middle school students and 73% of high school students with an ED classification had been suspended or expelled at least once (see Figure 1, Figure 2). (Wagner, Kutash and Duchnowski) These rates are significantly higher than the rates reported by other students with disabilities and students in the general population. In addition, a comprehensive study in Texas on the connection between school discipline and entry into the juvenile justice system found that, when controlling for other variables, youth classified as ED had a 24% higher probability than youth without a disability of being suspended or expelled.

According to the Office for Civil Rights at the U.S. Department of Education, students with disabilities are 12% of the overall student population, but make up a full quarter of the students arrested and referred to law enforcement in the school setting. (US Department of Education, Office for Civil Rights) In addition, the Texas study found that nearly half (48%) of Texas students classified as ED had eventual contact with the juvenile justice system compared to 13% of students without a disability (see Figure 3). (Fabelo, Thompson and Plotkin)

FIGURE 3: TEXAS STUDENTS WHO HAD CONTACT WITH THE JUVENILE JUSTICE SYSTEM



In 2008, the Mental Health/Juvenile Justice Action Network, supported by the John D. and Catherine T. MacArthur Foundation and led by the National Center for Mental Health and Juvenile Justice (NCMHJJ), began development of an SRM to disrupt school-justice pathways for youth with behavioral health needs. Based on a prototype pioneered by WrapAround Milwaukee, the NCMHJJ developed the SRM to

identify youth who are at risk for a juvenile justice system referral and may need behavioral health services. Juvenile justice and behavioral health leaders in Connecticut and Ohio tailored the model to their unique local resources and began implementation of SRMs. While the Connecticut and Ohio programs accomplish their goals through different mechanisms, they both turn away from school exclusion responses to focus on behavioral health need identification and community-based service provision. (Weiss and Skowyra)

WHAT DOES A SCHOOL RESPONDER MODEL LOOK LIKE?

There are several key components to any SRM. First, a cross-systems team must come together to plan and implement the initiative. Voices representing a range of stakeholders should be at the table from the outset of planning and should continue to monitor the initiative once implemented. Active involvement from a collaborative of law enforcement, schools, community behavioral health and family support service providers, and families and youth lays the foundation for a robust program structured for success. Additional stakeholders, such as probation professionals, may also bolster efforts. Judges are often particularly suited to function as conveners of these efforts, bringing the key stakeholders together to form the collaborative and helping the collaborative to develop a common vision for this work.

It is also critical to foster family and youth participation in this alternative path. An SRM will only be effective if students and families are willing to engage in the behavioral health screening and assessment process and to engage in behavioral health services that address any identified needs. Baggage that can come both with school discipline responses and from negative attitudes toward mental health needs can be a significant barrier to implementing effective SRMs. Family and youth engagement is therefore a key SRM component. Family representatives must be actively involved at every stage of planning and implementation. Grassroots community-based agencies can also be excellent planning partners, providing support that can help foster acceptance of the program among community members.

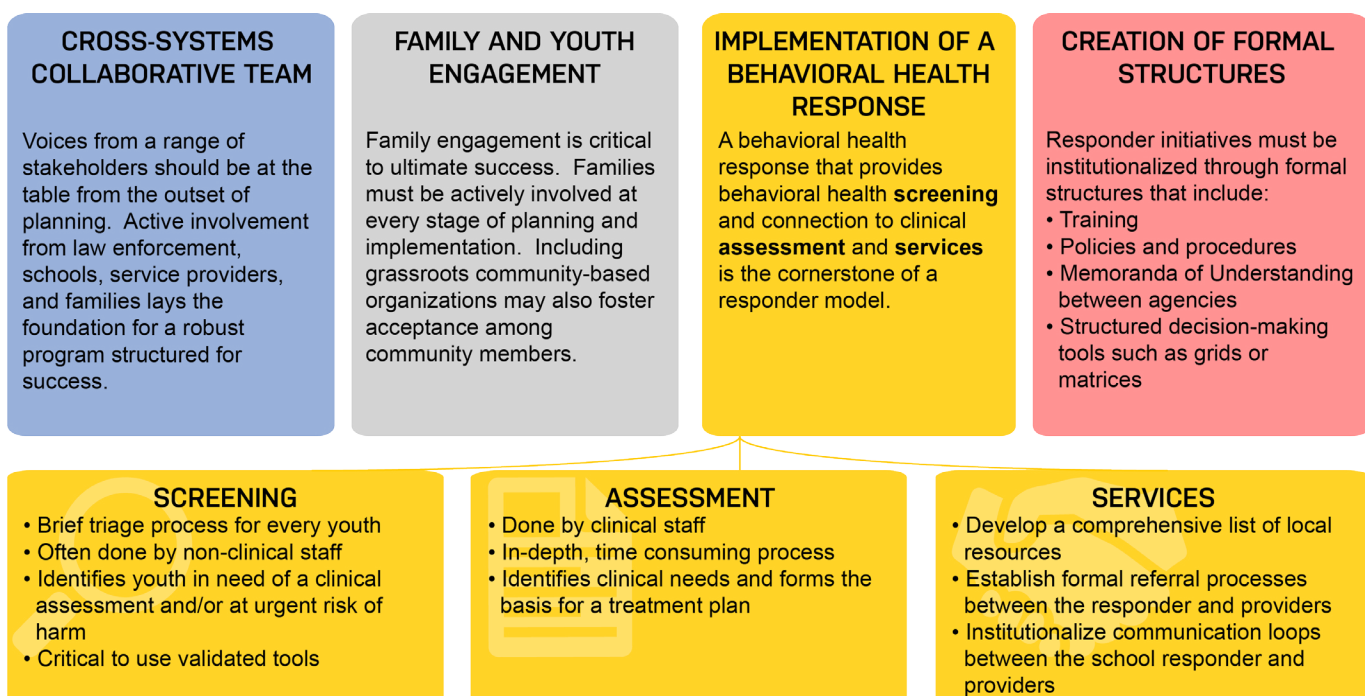
Third, all SRMs must develop a behavioral health responder in the school setting. The ability of school personnel to respond to or prevent school infractions by accessing a behavioral health resource instead of law enforcement is the cornerstone of any SRM. The responder must have the capacity to screen students for potential behavioral health needs and to either provide clinical assessment and services or to connect youth with those services. These three critical components of the behavioral health response are elaborated below.

1. **SCREENING**: a brief, triage process that can usually be completed by non-clinical staff. Through the use of a validated screening tool, staff can identify both youth with potential behavioral health needs who are therefore in need of a clinical assessment and youth who may be in need of urgent mental health care. It is important to note that diagnoses and case plans cannot be made from the results of a screening instrument. Any youth with an indication of need on a screening instrument should then receive a clinical assessment.
2. **ASSESSMENT**: a more time-consuming process of evaluation of the student done by a clinician. Assessments may include the use of various instruments, interviews with the child and family, collateral contacts, and reviews of existing behavioral health and academic records. Clinicians use the assessment process to identify any diagnosis, and the assessment results form the basis of the student's case plan.
3. **CLINICAL SERVICES**: interventions to address the behavioral health needs of the student. A collaborative must identify the existing service capacity in its community and then develop intentional pathways to those services for youth involved in the SRM. The capacity to provide targeted interventions known to meet the behavioral health needs of students is key to addressing the root causes of the school behaviors that brought the students into the SRM.

Creation of formal structures to embed the SRM into policy and practice is the final key component. SRMs must be institutionalized

through formal structures that will endure, including formal training; policies and procedures; and memorandums of understanding (MOUs) between schools and law enforcement and between schools and the service providers. In addition, structured decision-making tools, such as graduated discipline grids and service referral matrices, can be helpful to standardize practices across personnel. An additional example of this type of structured decision-making tool is a flowchart or ‘diversion map’ that walks staff through the diversion process.

The approaches taken by Connecticut and Ohio in developing their SRMs were driven by the availability of local resources and therefore resulted in two different structures. However, both structures found ways to build on local resources to include all the key components.



Connecticut’s structure, called the School-Based Diversion Initiative (SBDI), is built upon the strength of Connecticut’s Emergency Mobile Psychiatric Services (EMPS). EMPS existed in Connecticut prior to SBDI and, through the SBDI initiative, became available to respond to youth who have behavioral problems in school and who may have a mental health or substance use need. As of the fall of 2016, SBDI is in 37 out of 1148 schools and across 13 out of 200 of Connecticut’s school districts, including K-8, middle and high schools. EMPS has the

capacity to respond to a school within 45 minutes of a call for help and is sometimes able to respond more quickly. EMPS staff provide crisis stabilization, assessment, brief treatment, and linkage to ongoing care. School staff are provided significant training prior to implementation of SBDI so that they are better equipped to identify youth who may be in need of an EMPS response and to ensure that staff understand when and how EMPS should be called. (Bracey, Arzubi and Plourd)

A robust coalition of stakeholders works together to support SBDI at the school level, including, school leadership and staff, EMPS, family members and students, local law enforcement, juvenile probation, Youth Services Bureaus, Systems of Care Community Collaboratives, Juvenile Review Boards, Local Interagency Service Teams, and local Disproportionate Minority Contact Committees. The coalition provides participating schools access to a range of services and supports for youth that make diversion from juvenile justice system referral a realistic option. (Bracey, Arzubi and Plourd)

SBDI processes are institutionalized at the school level through MOUs between the school and EMPS. In addition, SBDI schools often revise their discipline policies to support the diversion initiative and sign memorandums of agreement (MOAs) with the police department to institutionalize a graduated response model for student misbehavior, diverting low-level student infractions from arrest to the SRM. (Bracey, Arzubi and Plourd)

The SRM in Ohio, called the Responder program, is built on the strengths of the Family Resource Center at the Summit County Juvenile Court. A strong collaboration between the juvenile court and the schools laid the foundation for this structure. Used largely in middle schools, this structure encourages schools to refer youth to the Responder program if school staff have concerns about the student's mental health, if the student is having behavior issues in school, or if there are concerns about school attendance. School personnel make the initial contact with the family to discuss referral to the Responder program. (Summit County Juvenile Court)

The Family Resource Center employs a case manager who is known as

the “Responder” for the school. The Responder works with the youth and family after referral from the school, screens the child for behavioral health needs, completes a more comprehensive assessment, develops a service plan, links youth to needed services, and monitors and supports the youth’s progress. Responder program services can last for up to 6 months if needed. (Summit County Juvenile Court)

ENGAGING CRITICAL



STAKEHOLDERS IN AN SRM

Engaging stakeholders who are critical to developing and implementing an SRM lays a strong foundation for the initiative. Judges are often well positioned to function as the convener of the various stakeholders who are essential to the SRM. While there may be many stakeholders who are important to the initiative, buy-in and engagement from youth and families, law enforcement, schools, and providers of mental health and substance use disorder services is crucial for successful program implementation. It is common for people from each of these stakeholder groups to feel stress in their current roles, overwhelmed, and under-resourced in their work. Answering the following questions may therefore be critical to obtaining their buy-in:

- What is the problem to be solved?

- Does this solution actually work to address the problem?
- How will an SRM benefit me in my role?

Several strategies can be applied to engage SRM stakeholders. They include: effective use of data, providing a compelling case for the efficacy of the model, development of a shared vision, strong and consistent communication, and solidifying engagement through an MOU or MOA.

EFFECTIVE USE OF DATA – DEFINING THE PROBLEM TO BE SOLVED

Efforts that successfully justify the need for an SRM are often rooted in a data analysis of a school's suspension, expulsion, and arrest practices. These analyses often gather information about the number of these incidents and disaggregate by disability status (measured by the presence and classification category of an Individualized Education Plan) and demographic information (e.g., race/ethnicity, gender, grade level, etc.). The sample data presentation below provides an example of how school discipline data can highlight disparate impact of suspension, expulsion, and arrest practices on students with disabilities and students of color.

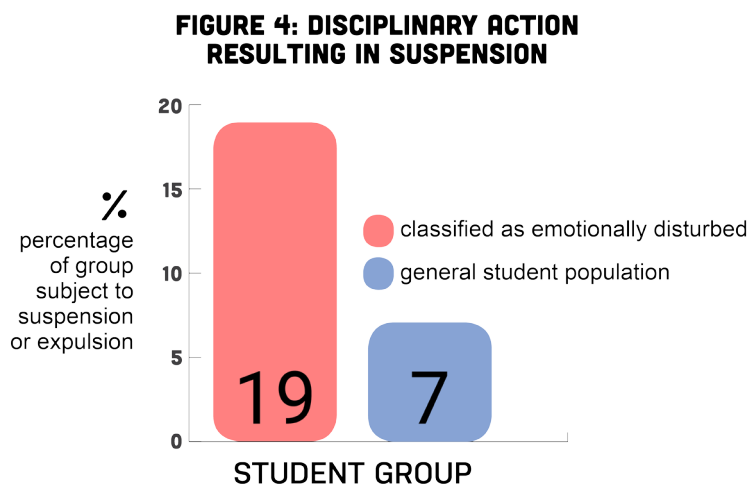


Figure 4 displays nationwide data to illustrate the disproportionate manner in which students with a disability classification are subject to exclusionary discipline in the form of suspension by comparing the proportion of the total student population suspended with the proportion of students with disabilities who are suspended. (Losen and Martinez) This graphic could be replicated using school-wide rather than nationwide data to illustrate disproportionality in an

individual school.

Figure 5 displays data to show the disproportionate manner in which Black students are subject to disciplinary action at a sample high school by comparing the school-wide demographic breakdown with the demographic breakdown of discipline offenses.

Many localities do not have complete data on hand at the outset of work on an SRM. It is often especially difficult to find a data source for school-based arrests. In this case, it is important to gather any data readily at hand and consider

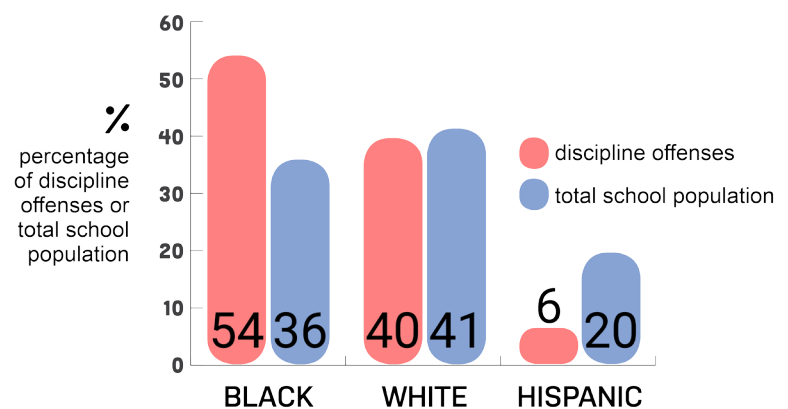
ways of improving available data. It can also be helpful to pair local data with data on national trends (as provided at the beginning of this technical assistance brief) in order to round out a compelling data profile. Comparisons between data on suspension rates, for example, at the local and national levels can make a compelling case for the existence of areas that need improvement at the local level.

PROVIDING A COMPELLING CASE FOR THE EFFICACY OF THE MODEL – DOES THIS WORK?

It is helpful to provide key stakeholders with information about the efficacy of the SRM in other jurisdictions as part of the case for use of the model to solve problems in their jurisdiction. Research on the SBDI in Connecticut and the Responder program in Summit County, Ohio, both provide compelling data on the need for and efficacy of the SRM.

The SBDI structure includes a focus on data collection and evaluation. The results among the 18 schools that have participated in SBDI since 2010 are impressive, with a 45% average reduction in court referrals during the first year of SBDI participation and a 94% average increase

FIGURE 5: PROPORTION OF TOTAL SCHOOL POPULATION COMPARED TO PROPORTION OF DISCIPLINE OFFENSES BY RACE/ETHNICITY (SAMPLE SCHOOL)



in referrals to behavioral health services. The strength of these results led to a new \$1 million state investment in SBDI for significant program expansion in 2016 and another \$1 million for additional expansion in 2017. (Bracey, Arzubi and Plourd)

Preliminary analyses of the Ohio Responder program are also promising. Over 75% of the 135 youth referred to the program between 2011 and 2013 successfully completed the program requirements. In addition, about 66% of youth who were referred to the program prior to any juvenile justice system involvement remained free of any charges 12 months after referral to the Responder program.

Evaluation results also indicate that behavioral health needs are often an important part of school behavior and attendance issues. While the vast majority of youth were referred to the Ohio Responder program as a result of attendance or behavior issues, over half (56%) of them triggered a level of concern when screened for a mental health or substance use need, and a large majority (89%) of them were referred for mental health services as part of their case plan. (Kretschmar)

DEVELOPMENT OF A SHARED VISION

It is helpful to build buy-in among stakeholders through the creation of a shared vision for the initiative. While each stakeholder group is likely to bring unique priorities and concerns to the initiative, common motivations can often be identified across groups. For example, diverse stakeholders are likely to agree that youth who have behavioral health needs should have access to services to address those needs, that school personnel and school culture and climate would benefit from an atmosphere with fewer disruptive behaviors, and that children with disabilities and youth of color should not experience disparate rates of exclusionary school discipline and school-based arrest.

One strategy for establishing a shared vision is to engage in an exercise in which all the stakeholders come together and define how things would be operating in 3 years once the initiative is fully implemented

and running effectively. Diverse stakeholders will often express common hopes for an effective initiative, laying the groundwork for a shared vision and providing a framework for the goals of the initiative.



STRONG AND CONSISTENT COMMUNICATION

As discussed above, effective cross-system collaboratives to support an SRM should be comprised of a diverse group of stakeholders. Representatives from a wide range of perspectives, including schools, families and youth, providers, and law enforcement, need to come together in support of a shared vision. Judges can play a key role in convening these stakeholders. Engaging, strong, and consistent communication across these cross-systems collaborative is critical to developing and implementing steps necessary to make that shared vision a reality.

Holding regular meetings of the collaborative is a key element to strong and consistent communication. Well organized meetings with a clear and consistent agenda often support stakeholder buy-in by setting the stage for productive meeting time and fostering a common understanding of initiative progress. If possible, holding these regular meetings face-to-face provides the richest opportunity to foster effective team communication and to build strong relationships across team members. Each member of the team should be careful to

communicate in shared language that is easily understood by all team members and in an authentic manner that is relatable to each member of the collaborative.

Communication loops should also include a feedback mechanism from the students, families and youth, and school personnel who are directly impacted by the SRM. Initially, the model should have the flexibility to respond to impacted stakeholder group evaluation and observation and every effort should be made to address stakeholder concerns and critiques as quickly as possible. Ongoing feedback from those impacted by the initiative will provide the team valuable information that can be used to support community engagement and optimize program design and operation.





SOLIDIFYING ENGAGEMENT THROUGH FORMAL AGREEMENTS

Once the necessary stakeholders are engaged in the collaborative effort and the team has been grounded in a shared vision for the SRM, it is important to solidify engagement through the use of formal agreements such as MOUs or MOAs. These agreements provide clarity around shared goals and responsibilities of participating organizations. They also provide a framework for the SRM that will outlast the participation of any one individual team member and lay the groundwork for sustainability in the face of institutional leadership changes.





ENGAGEMENT STRATEGIES FOR SPECIFIC STAKEHOLDER GROUPS – HOW WILL THIS BENEFIT ME IN MY ROLE?

In addition to the above general engagement strategies, which apply to all stakeholder groups, messages that resonate well with targeted stakeholder groups can be helpful. It is critical to develop clear messages that speak to the unique interests of each stakeholder group. The graphic below outlines some of these messages that may speak to members of particular stakeholder groups, as identified by members of each of the groups.






LAW ENFORCEMENT

-  officer time is preserved for high-level offenses
-  cost savings and recidivism reductions generated by providing interventions that work
-  SRMs provide a structure to reduce racial and ethnic disparities
-  this approach addresses root causes of behavior and helps families address needs at home





FAMILIES

-  include families in the SRM development process
-  avoid jargon and vague concepts
-  use short and simple messages with a tag line to begin the conversation; consider leading with an offer of help instead of arrest
-  use real family stories to inform a longer explanation of the initiative

SCHOOLS

-  reduce the frequency of expulsions, out-of-school suspensions, and discretionary school-based arrests
-  link youth to appropriate services and supports
-  build knowledge among school personnel to recognize and manage behavioral health crises in schools
-  initiative vision and plan developed in collaboration with school personnel
-  improve schoolwide attendance

SERVICE PROVIDERS

-  initiative provides an opportunity to connect services with schools
-  opportunity to educate other stakeholders on available services
-  improved access to school information (as legally allowed) and students in need
-  opportunity to better coordinate services for youth



(Bethel) (Graham) (Gollsneider) (Malloy)

IDENTIFYING YOUTH FOR DIVERSION

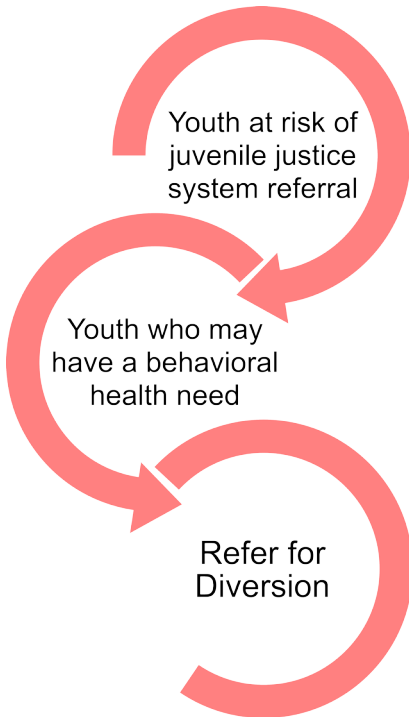
It is important to develop an objective and research-informed strategy to identify youth who are on the path to school-referred justice system involvement and who have behavioral health needs. The well-documented racial and ethnic disproportionality in referrals to the juvenile justice system, (Armour and Hammond) coupled with the data that reveals the disparate impact of exclusionary school discipline on youth of color and youth with disabilities, (Losen and Martinez) makes the use of standardized and objective procedures for identifying youth for diversion critical to the operation of a just and equitable initiative.

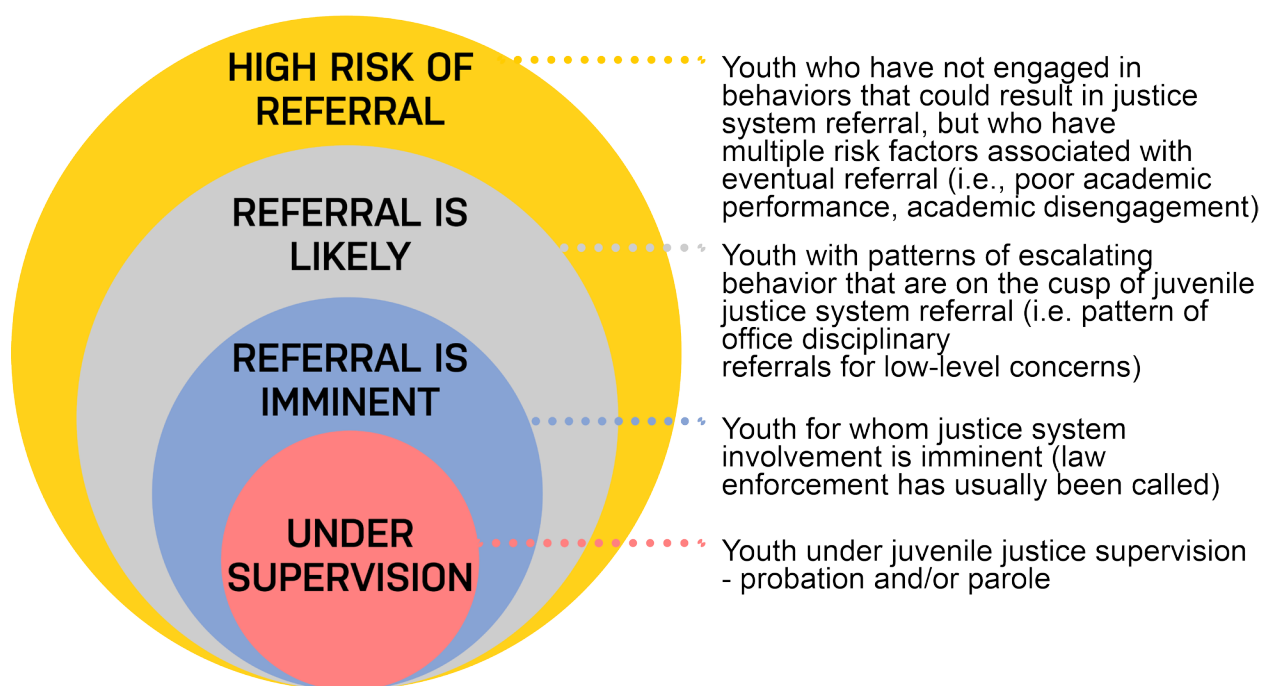
The student identification process can take the form of two discrete steps (at right):

1. IDENTIFYING YOUTH WHO ARE AT RISK OF JUSTICE SYSTEM REFERRAL

While there are many compelling reasons to consider a universal behavioral health screening approach in schools, (Eklund and Dowdy) the SRM takes a more targeted approach by first identifying youth who are at risk of referral to the juvenile justice system. This approach reserves resources for youth who are at the highest risk of referral into the justice system from school; fosters creation of an intentional relationship between the justice system, schools, and service providers; and steers clear of any complications that may result from implementation of a universal school-based behavioral health screening approach.

It is up to the local collaborative team to decide how to define the group of youth who are at risk of referral to the juvenile justice system. Potential definitions include the following:





The number of youth who fall into each group decreases as you move across this spectrum of definition. Teams will need to define the group of youth who are at risk of justice system referral after considering the benefits of each definition as well as the resources that will be necessary to include each group in the second step of behavioral health screening. Given that the goal of an SRM is to disrupt pathways from schools into the justice system, it is important to consider which definition will most effectively redirect youth away from ultimate justice system referral.

It is also important to consider how to systematize this step in the identification process. Teams will need to decide who among school personnel will be empowered to identify youth at risk of juvenile justice system referral and how the SRM will track the referral of these students to the screening process described below. Many SRMs allow for any adult to make an initial referral of a youth to the SRM, while others are more prescribed in requiring that a central person in the school functions as the gatekeeper to SRM services.

2. IDENTIFYING YOUTH WHO MAY HAVE A BEHAVIORAL HEALTH NEED

Once the population of focus—defined as youth who are at risk of justice system referral—has been identified, teams will need to create a process to identify which of those youth may also have a behavioral health need. Teacher referral—a method by which teachers independently identify youth that they believe may have a behavioral health issue—is the most common procedure that schools use to identify behavioral health issues. However, that model runs the risk of underestimating the behavioral health needs of students. Research has shown that relying solely on teacher referral can result in under-referral or in delayed referral. (Eklund and Dowdy) This kind of unstructured identification process also opens the door to implicit bias—attitudes and stereotypes that may unconsciously influence judgment or behavior—that may be present among adults functioning as referral sources or gatekeepers to a diversion opportunity.

Validated screening instruments offer a more objective method for identifying youth who may have a behavioral health need. These tools are generally brief and designed to be completed by non-clinical individuals. Some are designed for teachers to complete and others are designed for parents or students to complete. It is important to select an instrument that has been well-researched and shown to accurately identify potential behavioral health needs, both internalizing and externalizing, among youth who are the age of the population in your SRM.



The chart below provides an overview of some potential screening instruments to consider.

TOOL:	SCREENS FOR:	AGE/GRADE RANGE	LENGTH/ INFORMANT	FREE?	LINK
BASC-3 Behavioral and Emotional Screening System (BESS)	Externalizing problems, internalizing problems, adaptive skills, school problems	Grade: Preschool- grade 12/ Age: 3-18:11	25-30 items/ Teacher, parent, and self-report forms	No	http://www.pearsonclinical.com/education/products/100001482/basc3-behavioral-and-emotional-screening-system--basc-3-bess.html
CRAFT	Alcohol and drug use	Age: 14-21	3 screener items, 6 additional items/Self-report	Yes	http://www.ceasar-boston.org/clinicians/crafft.php
Global Appraisal of Individual Needs-Short Screener (GAIN-SS)	Externalizing behaviors, Internalizing behaviors, substance use, crime, violence	Age: 12-adult	23 items/ Self or staff administration	No	http://www.gaincc.org/GAINSS
Massachusetts Youth Screening Instrument (MAYSI, MAYSI-2)	Alcohol and drug use; anger/ irritability; somatic complaints; suicidal ideation; traumatic experiences; boys' thought disturbance (validated for boys only)	Age: 12-17	52 items/Self-report	No	http://www.nysap.us/MAYSI2.html
Pediatric Symptom Checklist (PSC)	Externalizing behaviors, internalizing behaviors, attention	Age: 4-18	35 or 17 items/Self, parent, or staff administration	Yes	http://www.massgeneral.org/psychiatry/services/psc_home.aspx

TOOL:	SCREENS FOR:	AGE/GRADE RANGE	LENGTH/ INFORMANT	FREE?	LINK
Social, Academic, and Emotional Behavior Risk Screener (SAEBRS)	Social behavior (externalizing, peer relations), academic enablers, emotional behavior (internalizing, emotional competencies)	Grade: K-12	19 items/ Teacher and self-report forms	Yes	http://ebi.missouri.edu/?p=1116 Alternative link: http://www.fastbridge.org/assessments/behavior-2/
Strengths and Difficulties Questionnaire (SDQ)	Emotional symptoms, conduct problems, hyperactivity/inattention, peer relationships, prosocial behavior	Age: 4-17	25 items/ Parent and teacher scales	Yes	http://www.sdqinfo.com/a0.html
Student Risk Screening Scale (SRSS)	Externalizing behaviors	Grade: K-12	7 items/ Teacher scale	Yes	http://pbiscompendium.ssd.k12.mo.us/system-tools
Student Risk Screening Scale - Internalizing and Externalizing (SRSS-IE)	Externalizing behaviors, internalizing behaviors	Grade: K-12	12 items/ Teacher scale	Yes	https://miblsi.org/evaluation/student-assessments/student-risk-screening-scale

SRMs have used various personnel to screen youth for behavioral health needs depending on existing community resources. Some models, such as Connecticut’s SBDI model, use mobile mental health crisis and stabilization teams to perform screening. Others, such as Summit County, Ohio, have created a Responder position within an existing Family Resource Center. Finally, some sites, such as Lyon County, Nevada, have built the screening function into the roles of school personnel who are engaged in other school initiatives such as Safe Schools/Healthy Students. A wide variety of school personnel could conduct screening, including teachers, social workers, psychologists, counselors, nurses, school-based health center staff, and administrators.

The results of a screening instrument are not sufficient to diagnose a behavioral health condition or to develop a treatment plan. Instead, youth who are flagged by a screening instrument should be referred to a clinical provider who can complete a comprehensive assessment. This assessment process can lead to an accurate diagnosis, followed by development of a service plan. Using a screening tool to identify youth who are in need of assessment may help preserve costly behavioral health diagnostic and referral services for those truly in need; administering a screening requires far fewer resources when compared to performing a comprehensive assessment.

CONNECTING YOUTH TO SERVICES

The efficacy of an SRM is rooted both in the capacity to accurately identify youth in need of behavioral health services and in the capacity to engage youth and families in evidence-based services targeted to specific needs. There are three basic methods that schools have successfully used to connect students to behavioral health services. They include:

1. School-linked models;
2. Community-partnered school behavioral health; and
3. School-based health centers.



1. SCHOOL-LINKED MODELS

This model of service provision is the most traditional model of behavioral healthcare. It systematizes linkages between students and a menu of off-site services provided by a community-based program. It is critical to formalize the connection between the service providers and the school in an SRM to facilitate the connection of youth to services. It is ideal to develop an MOA between the providers and the Responder that details services offered, referral and intake processes and timelines, crisis management, and structures for the legal sharing of health-related information. (Lever) These services may be supported by a variety of funding streams, including a student's private health insurance or Medicaid.

2. COMMUNITY-PARTNERED SCHOOL BEHAVIORAL HEALTH

In this model of service provision, students are offered behavioral health services in close connection with existing school programs, services, and strategies. A formal partnership, guided by youth and families, is established between school and service providers. Those providers offer services inside the school and often include a full array of tiered services, from school and classroom-wide strategies to promote mental health (for example, the Good Behavior Game or Positive Behavior Interventions and Support) to individual treatment for students with significant behavioral health needs. (Center for School Mental Health) While school-linked models work to connect students to behavioral health services in the community, community-partnered models expand the behavioral health capacity within the context of the school environment. A free online training curriculum on developing community-partnered school behavioral health can be accessed at <http://mdbehavioralhealth.com/training>. (Lever)

3. SCHOOL-BASED HEALTH CENTER

The school-based health center model of service delivery embeds behavioral health services into existing school-based health centers. Located inside a school building, these centers usually offer a range

of health services provided by local health organizations. Services can include behavioral health, offering a strong vehicle for integrating physical and mental health care. (Lever)

Regardless of the vehicle in place to connect youth to services, it is imperative that the staff working on an SRM have access to a systematic process for connecting youth and families to behavioral health services that effectively address their specific needs. While many communities may have an imperfect evidence-based youth behavioral health service continuum, it remains important to have a strong understanding of the existing service array and a process in place to quickly connect youth and families to those services. Existing service capacity should also be reviewed periodically by the SRM, as the array of providers and their services may shift over time.

PREPARING TO MONITOR PROGRESS

Once an SRM is in place, it is important to collect and monitor data in order to continually assess its efficacy. Efficacy can be defined as the capacity to both successfully connect youth with behavioral health needs to services and prevent movement of youth into the juvenile justice system. Careful program monitoring will help the collaborative team engage in continuous quality improvement (CQI) efforts to ensure that the initiative is meeting the intended goals.

WHEN TO PRESS GO

This technical assistance bulletin outlines key components and strategies for developing and implementing an SRM. Rooted in the experience of diverse communities across the country, the guidance offers an ideal structure for SRM implementation. Experience in various localities has also shown that realities of local systems and structures may result in enormous challenges in some part or parts of this ideal structure. Whether these challenges relate to accessing reliable data, stakeholders who are extremely challenging to engage, or a dearth of

evidence-based services for youth, many communities face significant barriers along their path to SRM implementation. It is important to remember that though the outcomes of changing systems to benefit children may not always be perfect, they are likely to be better. Teams should not hesitate to move to implementation if enough of the core components are in place to improve circumstances for students, even if the resulting structure is not ideal in every way.



RESOURCES TO GET STARTED

There are many resources available to guide teams in planning and implementing an SRM. An SBDI toolkit is also available through Child Health and Development Institute of Connecticut (CHDI) at <http://www.chdi.org/publications/resources/sbdi-toolkit-community-resource-reducing-school-based-arrests/>.

This toolkit includes many concrete tools that teams can build on to structure their initiative. Those tools include the following:

- Sample Memorandums of Agreement (page 41)
- Sample graduated response model (page 30)
- An overview of training structure and modules (pages 32-33)

The National Center for Mental Health and Juvenile Justice (NCMHJJ) has a website that outlines four basic steps to developing an SRM and includes links to many practical tools such as sample lists of team members, maps to organize multiple initiatives within a school, sample consent forms and MOUs, and a tool to assess readiness to launch. You can access this website at nmchjj.com/srm.

A video that provides an overview of SBDI can also be viewed at <http://www.ctsbdi.org/sbdi-model/video/>.

Several tools related to the Responder program in Summit County, Ohio, are also readily available. The Responder Program Development Manual is available at <http://www.modelsforchange.net/publications/450> and includes:

- A flowchart that outlines how this Responder program functions;
- A workbook that teams can use to walk through all the steps necessary to plan an SRM and move to implementation;
- Sample surveys and letters for parents and teachers to rate their experience with the Responder program;
- Sample forms, including initial screening, data tracking progress notes, and case disposition; and
- A power point presentation that provides an overview of the initiative.

In addition, the Summit County program developed a video and a brochure to explain the initiative to families. The video can be accessed at <https://www.youtube.com/watch?v=aebPsXJMOs8&feature=youtu.be> and you can find the brochure at https://juvenilecourt.summitoh.net/images/stories/pdfs/Brochures/responder_brochure.pdf.

Implementation of an SRM offers a real opportunity to address the root causes of behavioral issues in schools without shifting youth outside of the school setting or into the justice system. Once the right collaborative team is assembled and a process is developed, communities can often implement their SRM with little demand for new resources. Instead, the existing resources within schools, community providers, families and youth, and law enforcement function in a new way to identify behavioral health needs and access the services that effectively support youth in treatment. While an SRM will not entirely eliminate behavioral issues in schools, it can move schools and communities significantly in the right direction toward ending the disparate impact of exclusionary school discipline and referral to the justice system among youth who have behavioral health needs.

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