Justice Center
THE COUNCIL OF STATE GOVERNMENTS

STEPPING UP FOR YOUTH: KANSAS STATE TASK FORCE ON IMPROVING BEHAVIORAL HEALTH SERVICES FOR YOUTH WITH JUSTICE EXPERIENCES

KEY FINDINGS FROM STATE ASSESSMENT

September 13, 2024

Justice Center

THE COUNCIL OF STATE GOVERNMENTS

We are a national nonprofit, nonpartisan organization that combines the power of a membership association, serving state officials in all three branches of government, with policy and research expertise to develop strategies that increase public safety and strengthen communities.

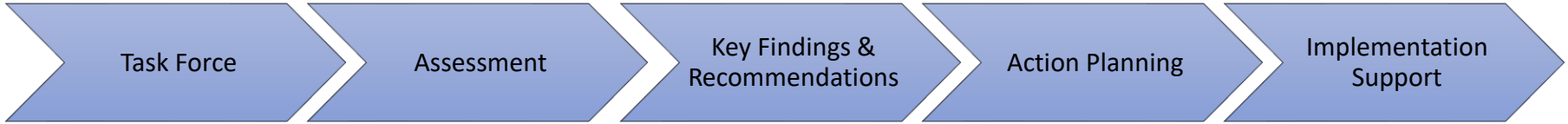
Stepping Up for Youth in Kansas: Initiative Overview

Stepping Up for Youth in Kansas

Goal of this initiative:

- Identify, implement, and expand best practices centered on improving community-based services, cross system collaboration, the efficient use of resources, and outcomes for youth with behavioral health needs who experience the juvenile justice system.

The state assessment has five key phases:



- Launch a task force to (June 2024)

- Review state policies, statute, data, and funding (Jan. - June 2024)
- Facilitate listening sessions (June – Aug. 2024)

- Present key findings and recommendations and build consensus (Sept.– Nov. 2024)

- Develop a detailed work plan (Dec. 2024 - 2025)

- Implement new state policies (2025-2026)

The Task Force oversees the assessment and represents diverse leaders committed to improving public safety and youth outcomes.

Clay McCarter, Director of Special Projects, KDOC	Jeff Butrick, Director of Community-Based Services, KDOC	Gary Henault, Director of Children's and Prevention Services, KDADS	Destini Gillian, Justice Involved Services Coordinator, KDADS	Brenda Soto, Director of Medicaid and Children's Mental Health, DCF	Ashley Brown, Cross Over Youth Policy and Practice Coordinator, DCF	Hon. Delia M. York, Wyandotte County District Court Judge
Rep. Stephen Owens	Rep. Angela Martinez	Rep. Brenda Landwehr	Rep. Susan Concannon	Rep. Timothy Johnson	Rep. Susan Humphries	Sen. Molly Baumgardner
Sen. Ethan Corson	Don Hymer, Chief ADA, Juvenile Division, Johnson County; Chair of JJOC	Sheriff Bill Carr, Ford County	Trish Backman, School Mental Health Coordinator, KSDE	Dr. Sherrie Vaughn, Executive Director, NAMI Kansas	Mike Fonkert, Deputy Director, Kansas Appleseed	Angela McHardie, Director, Shawnee County Juvenile Detention Center
Dustin Browning, Director of 4th Judicial District Community Corrections	Ann Sagan, Director of Special Projects, Kansas State Board of Indigents' Defense Services	Jennifer Zirkle, Intake Supervisor, NWKS Juvenile Service	Andrea Diaz Buezo, ACMHCK, Special Projects Coordinator	Marquetta Atkins, Executive Director, Progeny	Christopher Esquibel, Chief of District Court Operations, Office of Judicial Administration	Rachel Bell, Policy Analyst, Governor's Office

Key Questions for the Task Force to Consider

What behavioral health services are available to youth with and without justice involvement?

How do diversion, detention, and disposition policies account for behavioral health needs?

What cross-system collaborations support effective planning and implementation?

Are resources being utilized efficiently?

What data are being collected and what quality assurance processes exist?

Assessment Process and Key Findings

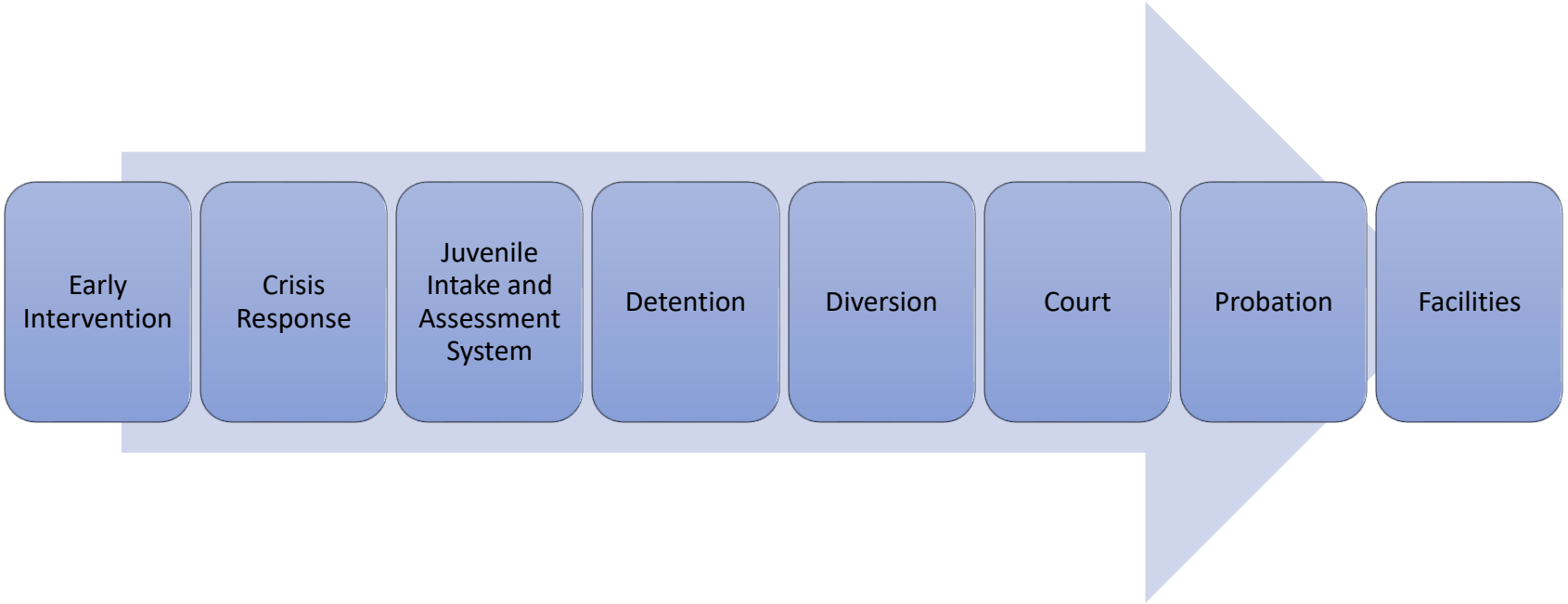
Key findings presented today are informed by a variety of assessment activities

System mapping across four agencies – KDOC, KDADS, DCF, and OJA – to review state polices, statutes, funding, data collection and quality assurance efforts

Review of existing data and reports across agencies, including database capabilities, aggregate data, and publicly available reports

Listening sessions with more than 120 stakeholders across the state including judges, behavioral health, schools, law enforcement, advocates, community-based organizations, child welfare, detention, juvenile intake, diversion, community supervision, facilities, others

We examined key intersections of juvenile justice and behavioral health interventions



Kansas has a strong foundation that can be enhanced to strengthen youth's behavioral health outcomes and public safety

Cross System Efforts in Statute	Cross Over Youth Policy and Practice Coordinators	Mental Health Intervention Team	Family Helpline
988	Mobile Crisis	Family Resource Centers	Status Offenses as CINC Cases
Risk Screening for CINC youth	Juvenile Intake and Assessment System	Crisis Intervention Centers & Crisis Respite Centers	Screening and Interventions in Detention

Key Finding # 1:
Kansas lacks a formal, statewide early intervention system that can prevent concerning adolescent behavior from escalating into self-harm, family conflict, or public safety concerns

There is a lack of a statewide strategy to implementing a continuum of services for youth's behavioral health needs

Formal working groups and cross-system policies exist but there are still gaps in system coordination, implementation, and buy in at the state and local level

Service planning lacks coordination, including intentional planning for rural/frontier counties, and does not use data to design a continuum of services with inclusive eligibility criteria across services

Youth do not have sufficient access to community-based services without system involvement

Two-thirds of youth in Kansas with a major depressive episode did not receive mental health services[1]

CMHCs lack dedicated youth staffing and approaches; 77% of youth served by CMHCs had a serious emotional disturbance (SED) and stakeholders reported gaps in services for youth without SED[2]

MHIT has high satisfaction across stakeholders but is not statewide and rural/frontier counties faced funding barriers

Rural and frontier counties cited significant service access issues

Community-based organizations can't access funding due to restrictions on prevention definitions and unclear deadlines

Stakeholders cited critical gaps in community-based services for youth with behavioral health needs

There is not a coordinated statewide service inventory across agencies, funding is not maximized, and some service slots go unused

Services that are available are often not scaled statewide, have long wait lists/response times, are unknown to other systems, and can exclude youth for a variety of reasons

Key gaps include respite, intellectual and developmental disabilities, alternative response, conflict mediation, restorative justice, peer supports, substance use, culturally aligned approaches, and interventions for status offenses like truancy and running away

There are a variety of crisis supports but law enforcement is primarily used when youth are in crisis

- When youth are in crisis, who should they call and where should they go?
  - 988, Mobile Crisis, Family Helpline, 911, Crisis Respite Centers, Family Resource Centers, Juvenile Intake and Assessment System, Community Mental Health Centers, Hospitals

- The family helpline responded to 487 youth crisis calls[3] compared to 11,210 intakes at the JIAS[4], which is primarily used as a law enforcement drop off
- Crisis Respite Centers exist in six locations but can refuse youth
- Family Resource Centers are in 10 locations and offer basic supports
- CMHCs mobile crisis have long response times of 12-24 hours

JIAS operations vary statewide but all face obstacles in serving youth in crisis

- Many youth are brough to JIAS in crisis and staff feel overwhelmed and don't have access to crisis supports or respite for youth
- JIAS operate statewide but vary in operations, for example some don't have an office, have different staffing models/hours, and most have not operationalized the youth/family walk in policy
- JIAS primary purpose is to provide a drop off location for law enforcement, conduct the detention and behavioral health screening and refer youth to services
- JIAS do not have diversion authority and service referrals are not connected to a full risk and needs assessments

Most youth brought to the JIAS by law enforcement have not engaged in serious public safety behaviors

Only 15% of all charges at intake were felony level charges[5], and 32% of intakes have no alleged criminal charges, including 48% of cross over youth intakes[6]

Of CINC intakes, 34% are for youth that are absent from home without consent[7]

60% of youth with delinquent charges receive a notice to appear at the JIAS and are not provided immediate supports[8]

The most frequent behavioral health symptoms reported by youth on the MAYSI-2 include somatic complaints (31%), depression and anxiety (25%), anger and irritability (25%), and suicide ideation (17%)[9]

Key Finding #2:
Kansas lacks a statewide behavioral health detention diversion strategy, continuity of care approach, and oversight supports

There are no formal alternative to detention statewide policies or behavioral health off-ramps for youth

- There is a statewide detention screening tool and a Juvenile Detention Alternative Initiative, but JDAI only operates in select counties and there are no requirements to develop a formal alternative to detention plan
- Crisis Intervention Centers are in the process of being established but stakeholders cited delays and confusion in the licensing regulations, and these will not be statewide
- Detention is used with CINC youth for behavior while in foster care, for example 43% of cross over youth with a special detention had a violation of a valid court order compared to 9% of other youth[10]

DCF licenses JDCs based on health and safety, and JDCs will soon be able to voluntarily participate in performance-based standards with KDOC

Current licensing requirements do not include a review of restraints, use of isolation, services, medication management, or other behavioral health indicators

There is basic data collection, but stakeholders reported the need for a centralized system and the desire to use data to understand performance

JDCs are primarily locally funded, and the level of funding is dependent on the income of the counties they serve

There is an alternative to detention fund with a $9M balance and $3.8M added annually

There is a lack of state policies and funding to ensure youth maintain continuity of care while in detention

There is a lack of policy and funding outlining how CMHCs can serve clients while in detention

New Medicaid options are being explored to promote continuity of care for youth in detention, but it is not a requirement

Recent legislation requires KDOC to ensure youth receive behavioral health supports in detention, but practices vary by facility

Some additional supports exist for cross over youth, such as complex case management across KDADS, DCF, and MCO for youth with SED

Schools reported the need for designated staff to ensure youth maintain credits and transition back to their home school with more supports

Key Finding #3:
Kansas lacks guidance on how to consider youth's behavioral health during diversion or disposition

Kansas has two agencies that supervise youth and the rationale for this approach is unclear

- Both Court Services and Community Corrections operate the Immediate Intervention Program (IIP) and probation for youth, local stakeholders determine which agency will run IIP
- Court Services does not receive any funding to operate programming and is supposed to supervise low and moderate risk youth
- Risk scores are supposed to determine which agency supervises youth, but risk distribution is similar across agencies and risk score thresholds are not consistent
- More than two-thirds of youth starting probation had low or moderate risks to reoffend[11]

Counties range in their IIP practices, but do not go beyond statutory requirements, including for youth with behavioral health needs

- In statute, IIP is required for first time misdemeanors and allows for any misdemeanor to be diverted but most County Attorney's limit this option even though 92% are successful[12]
- Stakeholders reported not all counties implement IIP as required by statute
- There are no other statewide criteria or risk tools to guide diversion decisions, including behavioral health needs
- There are no specialized behavioral health diversion options and schools reported the need for substance use IIP interventions to prevent suspensions and expulsions
- Due to local discretion and two different supervision agencies that can oversee IIP, services and requirements vary

Disposition to a supervision agency is not informed by behavioral health needs

The court does not receive behavioral health screenings from the JIAS and additional screens are not conducted to inform disposition

Judges reported behavioral health needs are not taken into consideration during disposition even though there are differences in funding and service availability across the two agencies

Competency evaluations and restoration services were raised as a concern, including the lack of services for restoration and dismissed cases due to being found incompetent to stand trial

Key Finding #4:
Services for youth on supervision vary by geography, supervision agency, and funding across systems are not maximized to meet youth's needs

There is a lack of specialized approaches at the intersection of juvenile justice and behavioral health

Mental health and substance use were reported as the biggest needs

Neither supervision agency has specialized caseloads or targeted strategies

There is a lack of specialized services for youth with juvenile justice involvement

There are gaps in data collection across agencies to inform services

JCABs lack structure and clear objectives for collaborative planning

State agencies lack a clear strategy to designate and leverage funding to implement youth behavioral health services

KDOC has an evidence-based fund with a $45.8M balance and $18M added annually, and KDOC reports districts return funds every year, and 10 districts did not apply for JCAB funds[13]

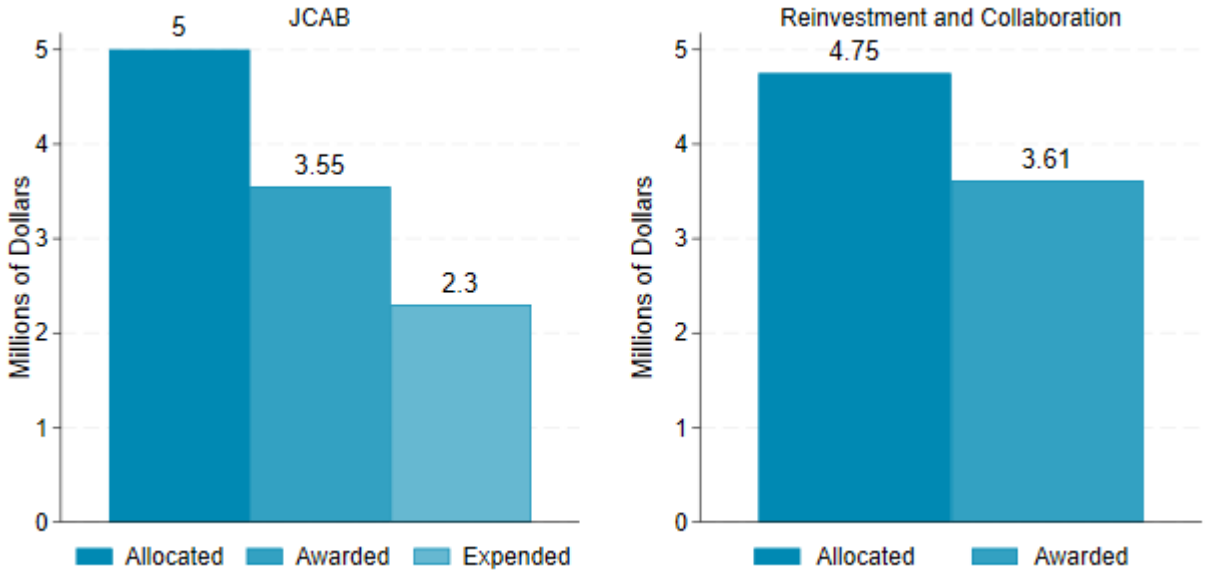
KDADS primary youth funding line is for MHIT at $19M and any school district can opt in for this service which requires a 35% match

DCF utilized the Evidence Based Services for Children with Delinquent Behavior funding, $2M, to purchase FFT slots but it is unclear how other funds, like Family First, had designations for crossover youth or youth that commit status offenses

OJA receives no state funding to support Court Services in implementing services

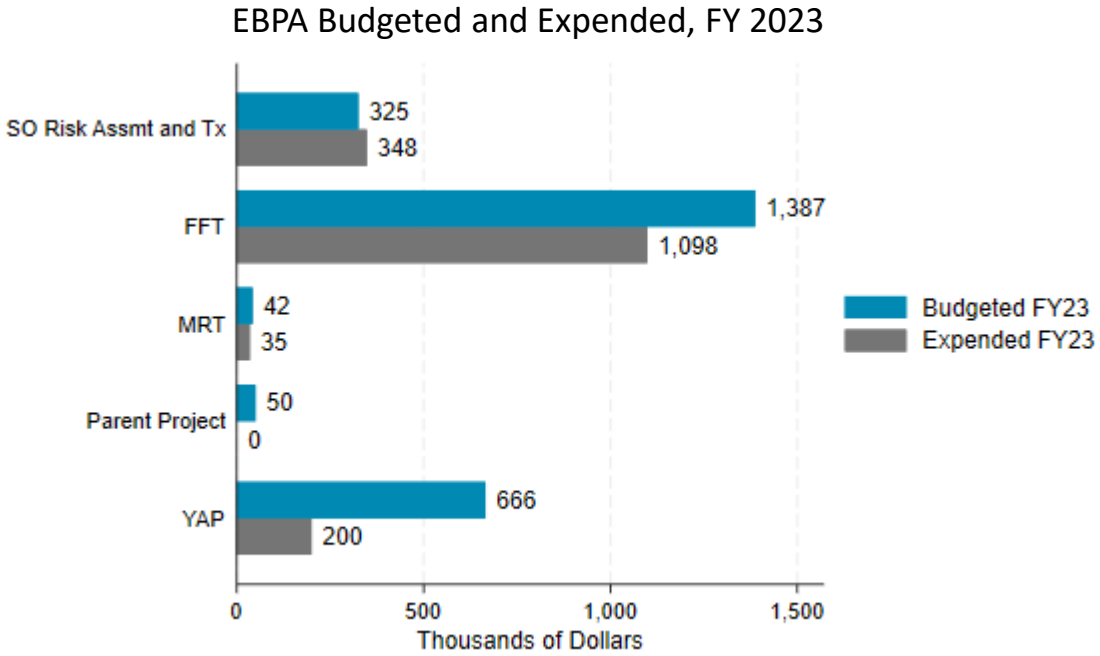
Funding is allocated for behavioral health services but is not being spent and risks being returned to the state general fund

Grant Funding Reported in JJOC Annual Report, FY 2023



In addition to JCAB and Reinvestment grants, JJOC allocated $750,000 for Mental Health Services, none of the funds were expended[14]

Statewide contracts exist but are not maximized



Medicaid is not being leveraged for all evidence-based programs, community response, violence interventions, or peer supports and slots for programs went unused

Key Finding #5:
The youth correction system is a primary provider of behavioral health services when some youth would be better served in alternative settings

Most youth committed to KJCC have a mental health diagnosis and face aftercare obstacles when returning to the community

- What are the behavioral health needs of youth in KJCC?
  - 77% have a mental health diagnosis
  - 43% have a significant mental health diagnosis and require individualized treatment plans
  - 41% take psychotropic medications[15]

- Only certain youth receive aftercare per statute, which is based on offense not need
- Stakeholders noted youth are released without proper care and cycle back to KJCC
- Cross over youth leaving KJCC do not have a central case manager and fall through the cracks navigating different staff

Psychiatric residential treatment facilities (PRTFs) are often not an available placement for youth with justice involvement

Many stakeholders cited significant frustrations with PRTFs, as they reject youth with justice involvement and these youth are left with no in-state options

PRTFs do not track data on youth with justice involvement

Some youth leaving KJCC qualify for PRTFs but are rejected and then are served in lower levels of care in the community which is insufficient based on their needs and leads to cycling back to KJCC

Some stakeholders cited the success of day schools offered by PRTFs which were available for youth even post-release, as these provided more comprehensive supports for youth

Overarching Takeaways

Overarching takeaways from the state assessment

Statewide coordination is lacking in implementing a continuum of youth behavioral health services
There is variability across the state in policies and services
CMHCs do not have designated youth staff or services, or tailored approaches for juvenile justice involvement
Juvenile justice agencies do not have specialized policies or approaches for youth with behavioral health needs across the continuum of diversion, detention, supervision, and reentry
There are significant gaps in data collection and quality assurance across intervention points with youth
Funding is not being utilized or maximized to establish needed supports

Discussion

Questions for Consideration

- Do these findings align with your experience?
- What findings stand out or surprise you?
- What do you see as the most important findings to be addressed?
- Are there any immediate policy or funding changes that you think would address core challenges?

Next Steps

Next Steps

Schedule the next task force meeting

Draft and share recommendations for feedback

Vote on recommendations

Present recommendations to various legislative committees

Citations

Citations

1. "Mental Health America Youth Data," Mental Health America, accessed August 28, 2024, https://mhanational.org/issues/2024/mental-health-america-youth-data. MHA reported data from SAMHSA's Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health.
2. SAMHSA, *Kansas 2022 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System.*
3. Carelon Behavioral Health, *Family Crisis Response Helpline Report, September 2023-August 2024*.
4. KDOC Annual Report, FY 2023, p.28.
5. KDOC Dashboard, JJOC Report, *Juvenile Intakes by Crime Type.* The figure reported may include more than one charge per intake.
6. Crossover Youth Working Group, *Final Report to the 2020 Kansas Legislature*, *Appendix H: Juvenile Intake and Assessment Findings*, Figure H.7.
7. Crossover Youth Working Group, *Final Report to the 2020 Kansas Legislature Appendix H: Juvenile Intake and Assessment Findings*, Figure H.8.
8. Kansas Juvenile Justice Oversight Committee, *2023 Annual Report*, p. 20.
9. Crossover Youth Working Group, *Final Report to the 2020 Kansas Legislature*, *Appendix H: Juvenile Intake and Assessment Findings*, Figure H.16.
10. Crossover Youth Working Group, *Final Report to the 2020 Kansas Legislature*, *Appendix H: Juvenile Intake and Assessment Findings*, Figure H.2.
11. Kansas Juvenile Justice Oversight Committee, 2021 *Annual Report*, p. 15.
12. Kansas Juvenile Justice Oversight Committee, *2023 Annual Report*, p. 2.
13. Kansas Juvenile Justice Oversight Committee, *2023 Annual Report,* p. 33.
14. Kansas Juvenile Justice Oversight Committee, *2023 Annual Report, p. 42.*
15. KDOC, *KJCC Mental Health Services Report, 2023-2024*.

Key Statutes

- Alternative to detention fund 79c(48)(3)
- Crisis intervention center 65c(5)(36)
- DCF oversight of youth with status offenses 38c(22)(2)
- DCF screening CINC youth for juvenile offender risky behavior H.B. 2021
- Detention screening tool 75c(70)(23)
- Immediate Intervention Program 38c(23)(46)
- KDOC ensuring behavioral health supports in detention H.B.2021
- KDOC evidence-based fund 75c(52)(164)
- KJCC placement matrix and aftercare 38c(23)(69)
- Mental Health Intervention Team, in proviso, S.B. 28 (p. 109-114)

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