# Youth Sequential Intercept Model
# Mapping Workshop

## November 2025

**Report for:**

## Lubbock County

Prepared by:
The Texas Judicial Commission on Mental Health

In Collaboration with
Lynfro Consulting
& D-Degree
Coaching and Training

JCMH
Texas Judicial Commission on Mental Health

# Youth Sequential Intercept Model Mapping Report for Lubbock County, TX

**Workshops Held:**

*Virtual Session:*
September 18, 2025

*In-Person:*
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**Final Report**:

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**The Texas Judicial Commission on Mental Health (JCMH**) was created by a joint order of the Supreme Court of Texas and the Texas Court of Criminal Appeals to develop, implement, and coordinate policy initiatives designed to improve the courts' interaction with—and the administration of justice for—children, adults, and families with mental health needs.

**Mission**

Engage and empower court systems through collaboration, education, and leadership thereby improving the lives of individuals with mental health needs, substance use disorders, or intellectual and developmental disabilities (IDD).

## RECOMMENDED CITATION

TEXAS JUDICIAL COMMISSION ON MENTAL HEALTH, YOUTH SEQUENTIAL INTERCEPT MODEL MAPPING REPORT FOR LUBBOCK COUNTY (2025).

## ACKNOWLEDGEMENTS

The JCMH is thankful for the assistance of the Lubbock County planning team: Marle Antu, Dr. Jeff Carr, Cynthia Fry, Judge Melissa McNamara, Frances Quintero, Chief Rick Saldana, Colie Shoaf, Craig Thomson, Dr. Nancy Trevino, and Dr. Sardar Zahid.

## FACILITATOR BIOGRAPHIES

**Lynda Frost**, JD, PhD, runs Lynfro Consulting, which is committed to helping foundations, nonprofits, and other agencies maximize their impact through clarifying mission-consistent goals, implementing effective programs, and optimizing internal operations. Lynda's skills have been honed through 25+ years in the nonprofit sector working to improve health, human services, education, and criminal justice outcomes for vulnerable communities. She brings to her work a unique combination of deep content knowledge and innovative process skills. She is passionate about designing fair and effective processes to reach each client's goals and is recognized for facilitating effective in-person *and* virtual meetings that inspire participants and deliver results. Prior to founding Lynfro Consulting in 2018, Lynda worked for 14 years at the Hogg Foundation for Mental Health and is an experienced administrator and attorney with expertise in human rights, juvenile and criminal justice, special education, and mediation.

**Doug Smith**, MSSW, ACC, is the Managing Partner of D-Degree Coaching and Training. He helps organizations develop strategies to address complex problems through creative facilitation and training. He also provides leadership training and coaching, especially for people most directly impacted by mental illness, substance use disorder, past trauma, and/or incarceration. Doug has 12 years of experience in mental health and justice policy, as a Senior Policy Analyst at the Texas Center for Justice and Equity and as an Adjunct Professor of Social Policy at the University of Texas at Austin. Doug has his Master's in Social Work and is also certified by the International Coaching Federation with an additional certification in Trauma-Informed Coaching. Doug also has lived experience of mental illness, substance use disorder, and incarceration, and these experiences drive his passion for prevention and community engagement.

## JCMH STAFF CONTRIBUTORS


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## A NOTE ON LANGUAGE

Across our communities, significant stigma still exists around experience with mental health disorders, substance use disorders, and justice system involvement. In this document, we seek to use respectful language that recognizes the value as well as the challenges that people with these experiences bring to our communities. Several excellent resources provide detailed guidance about language that feels more courteous and modern to many people. In general, it is a good idea to use "person first" language that references the person before a relevant condition (i.e., "a person with schizophrenia" rather than "a schizophrenic") because we are all more than one diagnosis or experience.

For more information on mental health language, see https://hogg.utexas.edu/news-resources/language-matters-in-mental-health.

For information on substance use, see https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction and https://www.thenationalcouncil.org/wp-content/uploads/2021/11/Language-Matters-When-Discussing-Substance-Use-1.pdf.

For information on disability, see https://www.cdc.gov/disability-and-health/articles-documents/communicating-with-and-about-people-with-disabilities.html.

For information on justice system involvement, see https://fortunesociety.org/wordsmatter/.

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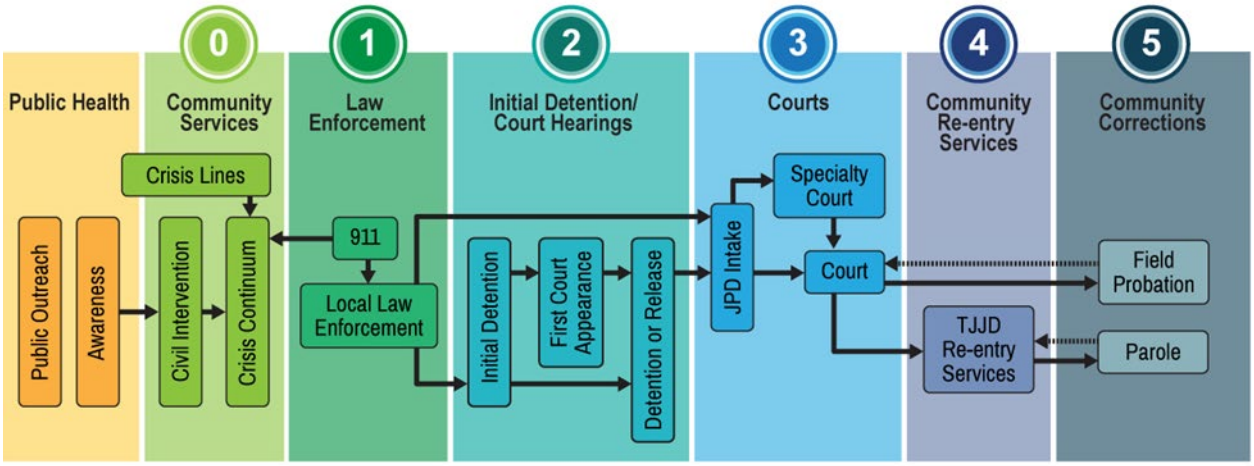



## EXECUTIVE SUMMARY

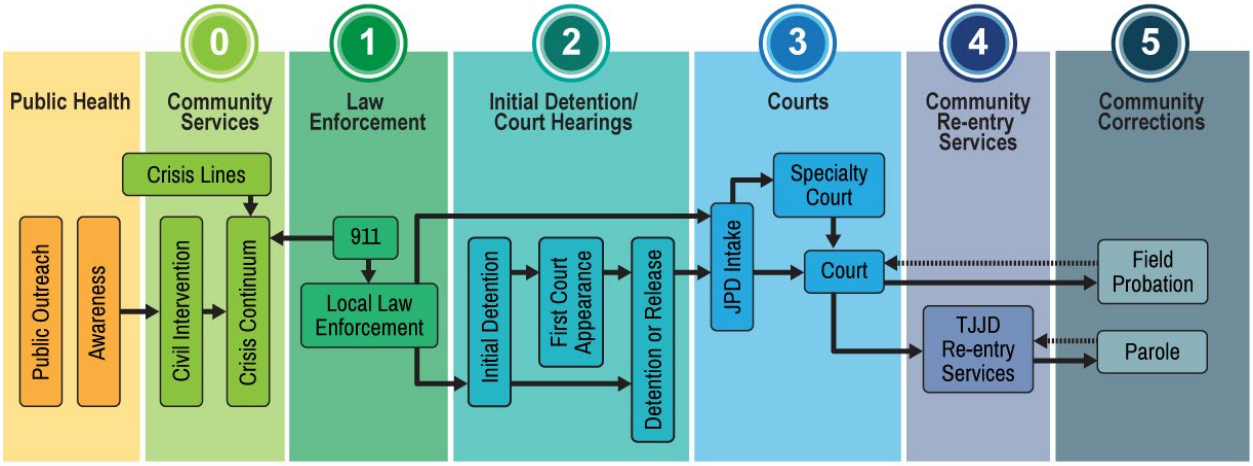
This report was created through a series of online and in-person workshops hosted by the Texas Judicial Commission on Mental Health to address the needs of youth with behavioral health challenges who become involved with the juvenile justice system. It draws on the Sequential Intercept Model to support communities in identifying strategies to divert youth from the justice system and into treatment. The workshops brought together 83 stakeholders from across systems, including mental health, substance use, schools, juvenile probation, courts, and law enforcement to map resources, gaps, and opportunities at each point a youth intersects with the justice system.

Through the workshops, participants identified increasing inpatient services for children and youth as the most important community priority. Work on this priority is already well underway. In addition to this top priority, the stakeholders developed priority action plans to improve coordination and services on four additional key priorities for change:

**Priority 1:** Community Resource Awareness and Identification
**Priority 2:** Case Management Across All Intercepts
**Priority 3:** Community & School-Based Identification Program
**Priority 4:** West Texas Mental Health Collaborative Child and Family Subcommittee

The report provides a detailed blueprint for Lubbock County stakeholders seeking to reduce unnecessary justice involvement for youth with behavioral health needs. As stakeholders move forward to implement the identified changes, it will be crucial for each action team to organize and track its steps as well as coordinate with other action teams. The Judicial Commission on

Mental Health will provide ongoing technical assistance as stakeholders review current laws and best practices to implement the plans.




## BACKGROUND

Young people with mental health and behavioral challenges are all too often referred to the juvenile justice system. These challenges may show up first in behavior at school or within overwhelmed families with little knowledge and support to help them address mental illness effectively. Time and again, these early interactions lead to multiple juvenile justice referrals and later adult criminal justice system involvement. All systems are impacted, from families to schools, mental health, child welfare, police, courts, juvenile detention, probation, etc. It takes everyone coming together to create a system that prevents referrals to the juvenile justice system and ensures the best outcomes for youth.

This Youth Sequential Intercept Model (SIM) Mapping process is based on the Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D., in conjunction with SAMHSA's GAINS Center, which has traditionally focused on the adult criminal justice system. Since its creation, it has been used by communities to assess available resources, determine gaps in services, and plan for change. During these workshops, the community develops a map illustrating how adults with behavioral health needs move through the justice system. The workshop allows participants to identify opportunities for collaboration to prevent further penetration into the justice system.

Texas communities recognized the relevance of this collaborative process to youth service systems as well as adults and began to request workshops focused on youth. The Judicial Commission on Mental Health (JCMH) participated in the Youth SIM Workgroup hosted by the Texas Health and Human Services Commission to review existing adult SIM mapping processes and develop materials and workshop content tailored to the unique needs of Texas youth. This work began with the understanding that kids are different from adults. Studies show that brains

are not fully developed until an individual is well into their 20s. Unlike adults, younger brains do not weigh consequences of actions as effectively and exhibit less impulse control. Executive function—which includes flexible thinking, self-control, and access to working memory that aids decision making—is not fully formed. In short, kids are kids, not adults.

Behavioral health challenges are the perfect storm for kids. Without the right system of support and treatments, they are far more likely to engage in behaviors and actions that are impulsive and often dangerous. Past trauma causes and exacerbates these challenges. The majority of youth in the juvenile justice system have histories of trauma, including physical and sexual abuse. Removal from home, school, and pro-social relationships is also traumatizing. It is absolutely crucial for a community to come together to address the consequences of trauma and prevent referral to juvenile justice systems.

## YOUTH SEQUENTIAL INTERCEPT MODEL MAPPING PROCESS

The youth workshop unites a wide array of community stakeholders, all of whom are dedicated to transforming the systems that impact young people with behavioral health challenges. By design, participants engage with people who work in unfamiliar systems. Juvenile court judges work alongside mental health providers or school superintendents. Parents brainstorm possibilities with police and probation officers. People with lived experience of juvenile justice involvement help to frame the discussion.

The mapping process is shaped with a planning team of local stakeholders who set the goals and principles that guide the process. The planning team also mobilizes a broad spectrum of community members from across the county or region representing parts of the system that can make a significant difference in the life of a young person at risk of or currently involved with the juvenile justice system.

The Judicial Commission on Mental Health (JCMH) process includes a virtual mapping workshop followed by a full-day in-person workshop. During the virtual session, participants meet key community leaders who can speak to the unique challenges they face and innovations they have tried at various points when youth are at risk of or currently involved with the juvenile justice system. Participants then identify the resources already available within the community that could provide better outcomes for youth in other parts of the system, especially if the resources were better coordinated and optimized. Next, the community identifies significant gaps and sparks discussion about possible innovations to address those gaps. The participants begin to sort

through the possible opportunities to see if there may be an emerging consensus behind certain priorities.

The process began in Lubbock County with a virtual session on September 18, 2025 through which community members identified resources, gaps, and opportunities to address those gaps. In preparation for the virtual session, a survey and interviews with key experts in the community helped to identify the resources and processes they use to address youth mental and behavioral health challenges. Recordings of interviews with key community informants were shared with other participants to help orient them to each intercept.

Following the virtual session, a broad spectrum of stakeholders convened for a one-day in-person workshop. Participants reviewed the resources and opportunities identified in the virtual sessions. They then generated ideas for system improvement and sorted through the ideas for impact and feasibility. The design ensures that community priorities that have the greatest buy-in from community members across systems rise to the top. These key ideas become the community priorities, and participants then work as teams to develop realistic action plans. Before leaving, participants identify priority champions who assume responsibility for ensuring that the teams continue to work on the priorities.

The in-person workshop for Lubbock County took place October 14, 2025. Following the workshop, the community has continued to work on their priority action plans. They also met virtually with JCMH to review and edit a draft of this report and again three months following the in-person workshop to check in on progress. Throughout this process and thereafter, the community may request free-of-charge technical assistance from JCMH.

## KEY FACTORS THAT SUPPORT THE EFFECTIVENESS OF THIS PROCESS

Communities that remain engaged and make significant progress toward their goals have key commonalities. Specifically, they draw on the participation from people with lived experience of mental health and behavioral health challenges or justice involvement, as well as their family members. Successful communities also create formal leadership teams to drive priorities forward. They make use of data to identify progress, adapt their plans, and optimize services. They also know the law as it relates to youth mental health and juvenile justice involvement.

## THE POWER OF LIVED EXPERIENCE

Family members of youth with mental and behavioral health challenges play a crucial role by providing other family members:

- Emotional support
- Shared knowledge
- Practical assistance
- Connection to people with resources
- Opportunities and communities of support

Having a family partner who is also addressing similar challenges helps other families to better understand behaviors, navigate complex systems, and advocate for their children. In Texas, Certified Family Partners receive training and certification, and they adhere to a common set of ethics and practices that empower other families to make the best decisions for themselves and their loved ones. Most, if not all, Local Mental Health Authorities in Texas employ Certified Family Partners, providing the families of younger clients with this crucial support.

Additionally, Certified Family Partners often play a key role in reducing stigma around mental health. Many families are hindered in seeking help for their children or loved ones because of misunderstandings about mental health and the shame they may experience when their children exhibit destructive or alarming behavior.

Family Partners help parents and caregivers know they aren't alone. Further, Family Partners provide key insights for stakeholders across the systems that help shape the community's efforts to improve outcomes for youth. The JCMH process always centers lived experience in the mapping process, ensuring that stakeholders hear from families and adults with lived experience of juvenile justice involvement.

In addition to Certified Family Partners, Texas also certifies peer providers to assist people with mental and substance use challenges. In Texas, the certifications include Mental Health Peer Specialists and Recovery Support Peer Specialists. A growing number of peer specialists also obtain certification as Re-Entry Peer Specialists who have lived experience with incarceration as well as recovery from mental health and/or substance use challenges. Re-Entry Peer Specialists can play important roles at any point at which young adults intersect with the adult justice system.

Several organizations and resources provide helpful guidance:

- PeerForce serves as a hub for peers and family partners in Texas, collaborating with communities and organizations to advance and broaden the peer career field. They provide assistance to prospective employers on how to implement peer services and provide training for prospective peers.
- Texas Certification Board certifies various types of peer specialists, including Certified Family Partners.
- SAMHSA is the federal agency that for decades has worked to promote peers in leadership roles.
- National Association of Peer Supporters
- Philadelphia's DBHIDS Peer Support Toolkit

## CONTINUED CROSS-SYSTEM COLLABORATION

Experience from counties across the state shows that the communities generating enduring results in their system change efforts are those that create formal coordinating groups such as the *West Texas Mental Health Collaborative* to facilitate and guide countywide justice and behavioral health cross-systems stakeholder planning.

This team of multi-agency stakeholders leading the collective effort to advance the priorities identified by the community should support team champions and include them in planning efforts. Continued coordination from representatives across sectors, including Texas Tech University Health Science Center, StarCare, behavioral health providers, school districts, juvenile probation, the judiciary, defense attorneys, and law enforcement along with people with current knowledge of adolescent mental health needs, evidence-based assessments, and treatments, will ensure lasting impact.

County stakeholders might also consider reaching out to other communities that have Behavioral Health Leadership Teams such as Texoma, Dallas, Denton, Kaufman, and more to share information and best practices. This list includes only a handful of communities, as many counties across the state have either launched or are initiating their own coordinating bodies. For technical assistance or connections to other communities, reach out to the Judicial Commission on Mental Health.

## EFFECTIVE USE OF DATA

Effective use of data improves decision-making across the spectrum of intercepts from community and school-based supports through juvenile probation. Strategic data gathering and

analysis also helps the community to track progress toward its goals. Communities that are adept at data analysis are also more likely to develop innovations previously unimagined.

Some key questions communities might consider as they seek to measure the impact of their initiatives include:

- Number of youth involved at the various intercepts,
- Key characteristics, such as Adverse Childhood Experiences (ACEs) scores, whether they are current clients of local mental health authorities, foster care involvement, and more,
- The key reason youth became justice-involved, or
- Measures of change as youth engage in programming.

There are only a handful of questions. As communities develop their priorities and actions plans, they might decide on the measures that best demonstrate progress toward their goals.

## UNDERSTANDING CURRENT STATUTES AND BEST PRACTICES

As communities map gaps and opportunities at each intercept, it is especially important to understand juvenile justice laws and responsibilities. Oftentimes, compliance with existing statute is hindered by the lack of cross-system collaboration and a lack of clarity about which entity is responsible for the law's implementation. Courts are uniquely positioned in this regard to bring together stakeholders and mobilize cooperative efforts to implement the law collaboratively on behalf of children.

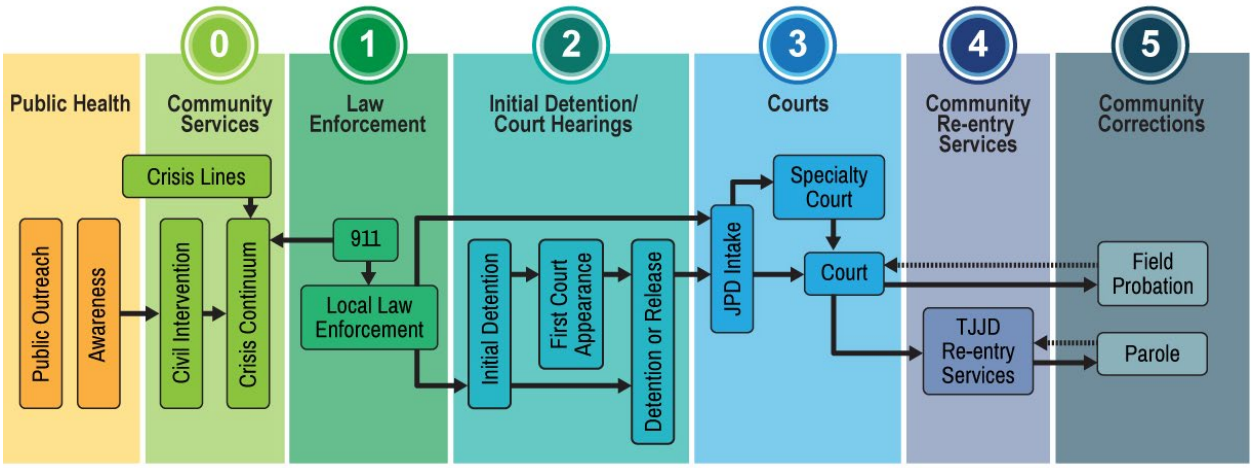
The Judicial Commission on Mental Health has released the Third Edition of the Texas Juvenile Mental Health and Intellectual and Developmental Disabilities Law Bench Book, which provides community and juvenile justice stakeholders with a comprehensive overview of best practices and existing laws at each point at which children and youth intersect or are at risk of intersecting with the juvenile justice system.

## RESOURCES AND CHALLENGES AT EACH INTERCEPT

An important objective of the workshop is to create a map of resources at each point at which a youth intersects—or is at risk of intersecting—with the juvenile justice system. The workshop's facilitators work with the participants to identify existing resources and gaps at each intercept. This process is essential to success since the juvenile justice system, schools, and behavioral health services are constantly changing, and identifying the gaps and resources allows for a contextual understanding of the local map. The map can also be used by planners to establish substantial opportunities for improving public safety and public health outcomes for youth with mental health and behavioral health challenges by addressing the gaps and building on existing resources.

Prior to the workshop, a planning team of Lubbock County leaders identified specific community goals for the workshop:

- Facilitate mutual understanding, collaboration and relationship building between a varied array of stakeholders, all of whom are dedicated to system transformation
- Identify best practices, resources, gaps in services, and opportunities for improvement and innovation across all SIM intercepts
- Prioritize key steps toward system transformation and improved service delivery and identify relevant best practices
- Create a longer-term strategic action plan with measurable outcomes, optimizing use of local resources and furthering the delivery of appropriate services




## INTERCEPT 0

**Intercept 0** encompasses the public health foundations that help youth and families through early identification of and response to challenges with mental health or intellectual and developmental disabilities (IDD). These foundations encompass basic needs, education, healthy food, safe neighborhoods, and other community-level supports. Intercept 0 also includes the array of community behavioral health and crisis response services designed to connect youth with appropriate services before a crisis begins or at the earliest possible stage of intervention.

### INTERCEPT 0 RESOURCES

| Public Health | |
|---|---|
| **Health Care** | |
| Care Options for Kids | Combest Central Community Health Center |
| Community Health Center of Lubbock | Covenant Children's Hospital |
| Department of State Health Services (DSHS): Region 1 | Larry Combest Community Health & Wellness Center |
| University Medical Center (UMC) Health System | TTUHSC Clinician Hotline |

| Basic Needs | |
|---|---|
| Community Resource Coordination Group (CRCG) | Family Promise of Lubbock |
| Lubbock Area United Way | Lubbock Dream Center |
| The Salvation Army Texas South Plains | South Plains Food Bank |
| **Community & Neighborhood Supports** | |
| Big Brothers Big Sisters of Lubbock | Lubbock Boys & Girls Club |
| LEARN Inc. | Lubbock Impact |
| YWCA Lubbock Community Youth Development (CYD) Program | |

| Intercept 0<br>Community Services | |
|---|---|
| **Mental Health & Behavioral Supports** | |
| Children's Behavioral Health Clinic at Texas Tech University | StarCare Specialty Health System (LMHA) |
| CPAN/PeriPAN Psychiatry Access Networks | Mobile Crisis Outreach Team (MCOT) |
| Relational Health Center at Covenant Children's Hospital | Oceans Healthcare (Abilene, Lubbock, Midland) |
| Youth Empowerment Services (YES) Waiver | Larry Combest Community Health & Wellness Center |
| NAMI Lubbock | Texas Child Health Access Through Telemedicine (TCHATT) |
| **Substance Use Resources** | |
| City of Lubbock Health Department Substance Use Service Assistance Network (SUSAN) | Helping Every Adolescent Achieve Dreams (H.E.A.R.D.) |
| Prevention Resource Center (PRC) Region 1 | |

| Residential Centers | |
|---|---|
| Boys Ranch (Amarillo) | Northwest Texas Healthcare System (Amarillo) |
| Perimeter Healthcare (Arlington, Dallas) | Rivercrest Hospital (San Angelo) |
| Saint Francis Ministries | |
| **Crisis Lines & Supports** | |
| 988 Lifeline | StarCare Crisis Line<br>806-740-1414 |
| Voices of Hope<br>24-Hour Sexual Assault Crisis Hotline<br>806-763-7273 | |
| **Child Protection & Family Supports** | |
| Buckner Family Pathways | Catholic Charities (FAYS program) |
| Children's Advocacy Center of the South Plains | DFPS Region 1 |
| Medically Dependent Children Program (MDCP) | Methodist Children's Home Family Outreach |
| The Parenting Cottage | Children's Home of Lubbock Family Success Program |
| Texas Tech University Family Therapy and Psychology Clinics | Women's Protective Services of Lubbock |
| **School-Based Resources** | |
| Communities in Schools of the South Plains | Early Childhood Intervention (ECI) |
| Lubbock ISD REACH Program | Region 17 Education Service Center (ESC) |
| Systems of Behavioral Response to Intervention (RTI) and Multi-Tiered System of Supports (MTSS) | Teen Outreach Program (TOP) |

**Expanding Access to Care Across Systems**

Dr. Sarah Mallard-Wakefield is a leading voice in children's mental health and a driving force behind Texas Tech University Health Sciences Center's (TTUHSC) growing continuum of care for kids in West Texas. As Chair of Psychiatry at TTUHSC's School of Medicine, she oversees programs that are reshaping how schools, hospitals, and juvenile justice systems respond to youth at risk.

With board certifications spanning child, adolescent, forensic, and reproductive psychiatry, Dr. Wakefield's expertise allows her to lead across multiple settings—meeting young people where they are and ensuring they receive the right care at the right time.

One of her team's key innovations is a **clinician hotline** that offers real-time consultation to community providers and free one-time telehealth assessments for families. With over 800 schools connected, this service is helping children gain timely access to needed support.

She has also driven the creation of a **day treatment program at Covenant Children's Hospital**, expanded services at the **Lubbock County Juvenile Justice Center**, and school-based early intervention programs. Together, these form a continuum of care that simply didn't exist a decade ago.

Through her work, TTUHSC is expanding access to care and reshaping the way West Texas nurtures its most vulnerable children.

## INTERCEPT 0 GAPS AND OPPORTUNITIES

The community identified several challenges at Intercept 0, noting that many children and families experience significant barriers long before contact with law enforcement or the juvenile justice system. Stakeholders consistently cited the absence of an inpatient hospital for children in Lubbock County. In fact, during the in-person workshop, this became the number one priority with nearly everyone in attendance ranking it as the highest priority. Lubbock County is well on its way in creating an inpatient hospital for children and youth with an anticipated 2027 opening.

Participants also noted a shortage of psychiatric providers accepting Medicaid or Medicare as a major gap. The lack of systematic coordination between schools, child welfare, and juvenile justice programs was said to cause fragmented care, leaving youth and families uncertain about how to access help.

Community members also emphasized the strain on providers, high staff turnover, and limited funding for prevention or early intervention programs. Participants noted geographic disparities with “resource deserts” in parts of the county where behavioral health and family supports are scarce. A lack of transportation and poor awareness of available services further compound access issues.

Participants viewed these barriers as opportunities to strengthen coordination, improve communication, and build infrastructure that connects families to resources earlier. Many called for centralized resource mapping, consistent referral systems, culturally competent and family-centered programming, and increased funding for both prevention and outpatient care.

Identified Gaps:

- No inpatient hospital options for children in Lubbock County
- Shortage of psychiatric care providers, especially those accepting Medicaid/Medicare
- Medication availability and cost barriers
- Limited services for children outside the IDD category who still need behavioral support
- Weak coordination between schools, juvenile justice, and child welfare systems
- Limited knowledge and awareness of child mental health resources
- Poor communication between schools and community providers
- Resource deserts in parts of the county
- Lack of “kid-friendly” transportation and public transit
- Gaps in culturally competent care and parent education programs
- High staff turnover and inconsistent experience among providers
- Funding shortages across prevention and family support services

Opportunities for Innovation:

- Recruitment and retention of behavioral health providers accepting Medicaid
- Develop inpatient and outpatient services for children locally
- Centralized “hub” or repository of resources for youth and families
- Interactive community resource mapping
- Funding for prevention and family support services through schools
- Improved workflow coordination across systems
- Parent access to substance-use services and detox centers
- Expanded respite services for families in crisis
- Systematic referral and navigation processes
- Greater collaboration between school systems and juvenile justice
- Infrastructure funding to strengthen provider capacity

**Close to Home, Surrounded by People Who Care**

Marle Antu has worked within Lubbock County's mental health system for 20 years, shaping services for youth with serious behavioral health challenges. Now Chief of Behavioral Health Operations at StarCare, she has risen from children's case management to leading strategy for youth and adult programs.

Still, she says children's services are "where I grew up."

Under her leadership, StarCare tailors care to each child's needs, offering assessment-based case management, skills training, parent education, and wraparound services for families requiring intensive support. Her programs serve more than 360 children, integrating therapy, medication, and family-centered care.

Marle has also championed innovations for youth at risk of justice involvement or out-of-home placement. For instance, the Multi-Systemic Therapy program, launched three years ago, provides intensive, family-based treatment that addresses behavioral issues across home, school, and community systems—helping young people remain in their communities.

Additionally, the YES (Youth Empowerment Services) Waiver delivers coordinated, strength-based wraparound care that includes therapy, respite, family training, adaptive aids, and crisis supports to help children with serious emotional disturbances stay stable and thrive.

Through it all, Marle's work reflects her belief that every child deserves the chance to heal and belong—close to home, surrounded by people who care.

## INTERCEPT 0 BEST PRACTICES

### BEST PRACTICE: EARLY INTERVENTION – TRAUMA-INFORMED SYSTEMS

There is an undeniable correlation between adverse childhood experiences and later juvenile justice involvement. Without early detection and intervention, the consequences for children are quite severe. Young trauma survivors may experience cognitive impairment and other health risks. It is very common for youth who did not receive early intervention to exhibit problematic and sometimes criminal activity, including harmful substance misuse.

Many children demonstrate signs of traumatic stress early and throughout their childhood. Preschool aged children might have nightmares or have extreme fear of separation. Elementary school aged children might demonstrate inordinate levels of guilt and shame or have difficulty concentrating. Children might show signs of depression, eating disorders, and drug use.

It is crucial for pediatricians, teachers, counselors, and caregivers to learn to identify and address unresolved trauma in young children before it manifests in problematic behavior and other lifelong consequences. Trauma-informed systems consistently recognize that many young people and families have lived through trauma, whether as a single overwhelming event—such as witnessing or experiencing violence—or as chronic adversity repeated over time. Trauma can involve multiple types of harm, making many youths' histories complex. At its core, trauma is the combination of exposure to overwhelming or dangerous events and the lasting stress reactions—thoughts, emotions, body responses, and behaviors—that develop as the young person tries to survive and stay safe. These reactions, such as freeze, fight, flight, or shut-down, may protect a child in the moment but can later interfere with learning, relationships, health, and safety if no one helps them understand and adjust them.

A trauma-informed approach focuses on how trauma shapes behavior and relationships, responding in ways that build safety, trust, and hope instead of adding harm. It recognizes that behaviors like "acting out," shutting down, or using substances may, in some cases, be survival strategies rather than defiance or pathology. The goal is to help youth recognize these reactions, keep what protects them, and replace what harms them with healthier coping and connection. Being trauma-informed also includes attending to the well-being of adults, because hearing about or witnessing trauma can produce secondary traumatic stress. And when youth are involved in multiple systems - such as schools, probation, treatment, and child welfare - it becomes essential to coordinate care, reduce repeated questioning, and design policies and environments that minimize the risk of re-traumatization.

As the community develops its strategy, it might consider training from Educational Service Centers and pediatric associations. Parents can also learn to identify and address trauma in a patient and compassionate manner.

## BEST PRACTICE: INTENSIVE CARE COORDINATION

Serious mental and emotional disorders among children represent the most complex and costly challenges to Texas communities. The Centers for Medicare and Medicaid Services in

collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) identified the need for Intensive Care Coordination (Wraparound) services for youth and families, especially when their needs exceed what a single agency could provide. They recognized the need for a flexible and individualized approach to serving youth and families with complex challenges. Texas is an early adopter of the wraparound model of care.

To be successful, wraparound services must move beyond a single agency to include shared responsibility between organizations. The seven components of intensive care coordination include:

1. Assessment and Service Planning
2. Accessing and Arranging for Services
3. Coordinating Multiple Services
4. Access to Crisis Services
5. Assisting the Child and Family in Meeting Needs
6. Advocating for the Child and Family
7. Monitoring Progress

## BEST PRACTICE: FOSTER EARLY MENTAL HEALTH IDENTIFICATION AND INTERVENTION

According to research, nearly half of all mental illness starts before age 14, yet early identification and intervention strategies remain inadequate for youth. Most frequently, the mental health challenges first present themselves as crises at the emergency room, not in schools or in mental health clinics. Failure to intervene early can have long lasting impact well into adulthood. Often youth with untreated mental health challenges self-medicate with drugs and alcohol, leading to co-occurring mental health and substance use disorders. It is imperative that communities develop early identification strategies that extend beyond emergency rooms and first responders.

While some physicians conduct early and periodic screening, diagnosis, and treatment, these are services covered only by Medicaid. A more robust strategy would involve incentivizing pediatricians and family care physicians to conduct screenings. Through the Child Psychiatry Access Network (CPAN), any pediatrician in the state can be connected with a mental health expert within 5 minutes to do a consultation on a child with concerning psychiatric symptoms.

School-based screening can also be effective, making it crucial to involve school districts in communitywide efforts to identify and treat childhood mental illness early.

All these efforts are important, but they may require policy changes, whereas communities can initiate communitywide awareness efforts at any time. Parental education and resource awareness not only helps families know who and when to call for help, they also reduce stigma associated with mental illness.

## BEST PRACTICE: MENTAL HEALTH AND JUVENILE JUSTICE INTERAGENCY COLLABORATION

While Lubbock is already a model of Mental Health and Juvenile Justice Interagency Collaboration, it is helpful to refer to best practices in this regard. For instance, goal of interagency collaboration is to learn from each juvenile referral, through data analysis and dialogue, to develop innovative approaches to prevent future juvenile referral for at-risk youth. Some principles of effective collaboration may include:

1. Commit to Formalized, Sustained, Integrated Approaches and Cross-System Collaboration Between Mental Health, Juvenile Justice, School, and Youth-Serving Organizations.
    - Create a core team of multi-agency stakeholders to implement and monitor diversion efforts.
    - Develop a continuum of evidence-based and trauma-informed services for youth and families outside the juvenile justice system.
    - Bolster protective factors that strengthen family connections and individualized support for both youth families.
2. Utilize Standardized Mental Health Screening and Assessment Tools
    - Ensure that juvenile justice and mental health agencies mutually select the appropriate assessment and screening tools and provide common training on the use of these tools.
    - When screening indicates a need for further evaluation, employ an individualized assessment of the needs, strengths and barriers of both the young person as well as their family.
    - Ensure that none of the information collected for mental health screening and assessment jeopardizes the legal interests of the youth.
3. Develop a Continuum of Evidence-Based Treatment and Practices
    - View the youth's mental health needs from the lens of responsivity; when a young person is experiencing mental health symptoms, their ability to learn and change

behavior is limited. Identify and treat the mental health symptoms to improve responsiveness to interventions designed to address criminogenic needs.

- Ensure that all partners, including school staff, teachers, law enforcement, juvenile services staff, and mental health providers are all trained on how to identify mental health symptoms and signs of crisis. All partners should be trained on how to therapeutically respond and de-escalate the situation.
- Ensure that youth who are diverted from the juvenile justice system are connected with community resources in a coordinated manner. Aim for services within the least restrictive setting.
- Continually assess the capacity of local resources across the community to provide evidence-based and trauma-informed services, including mental health and substance use. Collaborate to continually expand capacity through interagency coordination and service optimization.

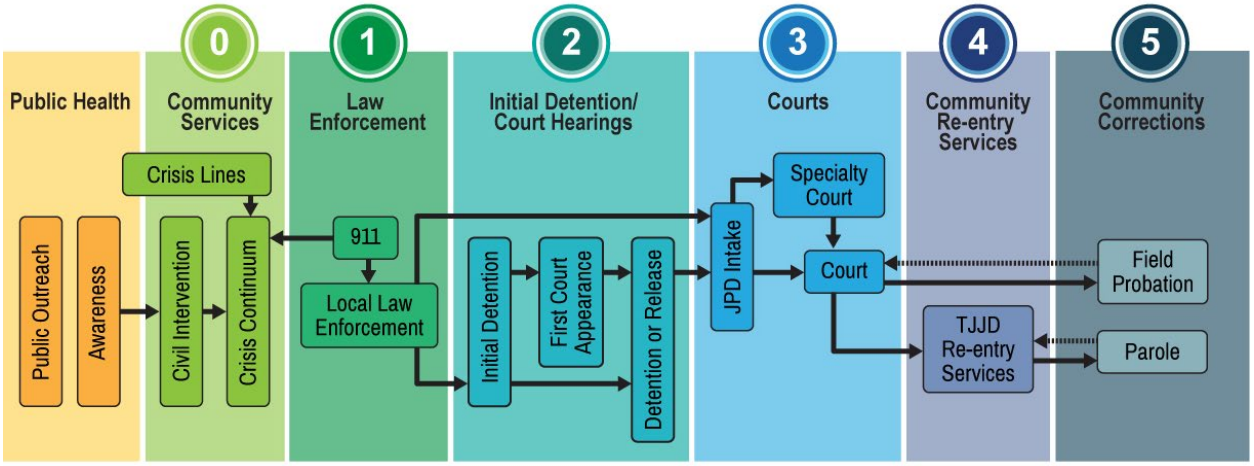
4. Provide Specialized Training for Intake or Probation Officers
    - When juvenile referral is necessary, such as when youth behavior puts them at risk of harm to themselves and others, ensure that specialized officers are extensively trained on working with youth with mental health diagnoses.
    - Ensure that probation officers are experts in screening and assessments. Mental health agencies should provide continual support and training to ensure probation staff have the resources they need to effectively serve youth with mental health diagnoses.
    - Work collaboratively across systems, including juvenile services, schools, and youth-serving organizations, to improve family engagement. View family engagement as the goal and responsibility of all organizations.

## BEST PRACTICE: ESTABLISH GOALS FOR YOUTH CRISIS CARE

Some of the goals of to work toward may include:

- Keep youth in their home and avoid out-of-home placement as much as possible. The YES Waiver Program, which provides a highly individualized set of services that are tailored to specific youth and family needs, is a good example of wraparound care that prevents out-of-home placement.
- Integrate family and youth peer support, ensuring that caregivers are paired with Certified Family Partners and kids with youth peer support.

- Communities should also ensure that everyone who plays a role in youth crisis response, from law enforcement to mental health authorities are trained appropriately and help to design the tailored response by the community.


## INTERCEPT 1

**Intercept 1** focuses on the initial contact with law enforcement and encompasses the array of responses to youth with mental illness or IDD who may be engaging in delinquent conduct, experiencing mental health crisis, or both.

## INTERCEPT 1 RESOURCES

| Intercept 1<br>Law Enforcement | |
|---|---|
| Lubbock County Sheriff's Office | Lubbock Police Department<br>Mental Health Peace Officers & Crisis Team |
| Lubbock ISD Police Department | Frenship ISD Police Department |
| Shallowater ISD Police Department | Idalou ISD Police Department |
| Lubbock-Cooper ISD Police Department | Slaton ISD Police Department |
| Slaton Police Department | Shallowater Police Department |
| New Deal Police Department | Idalou Police Department |
| Wolfforth Police Department | |

**“That’s When Lives Really Start to Change”**

Chief Ray Mendoza leads the Friendship ISD Police Department in Wolfforth, Texas—a team of 20 officers that prioritizes education and discretion over criminalization. Every campus has at least one officer, two at the high schools, working side by side with educators to keep students, staff, and visitors safe. But for Mendoza, safety is just the starting point.

“We’re not here to criminalize typical schoolyard behavior,” he says. “We’re here to educate and protect.”

Under his leadership, Friendship ISD handles issues like vaping or minor in possession as school-based violations, not criminal cases. It’s a practical approach that gives kids room to learn from mistakes without lasting harm. His officers are also trained to respond thoughtfully to behavioral health crises, consulting with counselors and administrators before any emergency detention.

“We never take that lightly,” Mendoza says.

What drives him most is connection with students such as the high-fives in hallways and the expressions of gratitude that often come years later.

His hope is stronger family engagement and community collaboration.

“When schools, families, and the community come together,” Mendoza says, “that’s when lives really start to change.”

## INTERCEPT 1 GAPS AND OPPORTUNITIES

At Intercept 1, the community highlighted gaps in how first responders and law enforcement handle youth in crisis. Stakeholders observed that school personnel and police often lack training to recognize or de-escalate mental health symptoms, leading to reactive rather than therapeutic responses. Participants indicated a need for trauma-informed and child-specific crisis response, emphasizing that Lubbock lacks sufficient mobile crisis staff to respond effectively in real time.

The community also viewed these gaps as opportunities to build partnerships between law enforcement, schools, and behavioral health systems. Community members discussed the value of joint and ongoing training, the creation of mobile response teams with child clinicians, and the

integration of Youth Mental Health First Aid into police departments. Collaborative interagency training was viewed as a pathway to more compassionate, effective responses to youth in crisis.

Identified Gaps:

- Lack of de-escalation and trauma-informed training
- Insufficient education for school personnel about mental health, gangs, and substance use
- Lack of education for first responders on youth mental health symptoms
- Absence of crisis response teams dedicated to children
- Limited staffing for non-arrest cases needing referral or follow-up support

Opportunities for Innovation:

- Specialized training in child crisis response
- Collaborative training between law enforcement and community organizations
- Expansion of mobile crisis response teams with child clinicians
- Implementation of Youth Mental Health First Aid training for police
- Interagency training to standardize and align practices across systems

## INTERCEPT 1 BEST PRACTICES

### BEST PRACTICE: CO-RESPONDER APPROACH

In a Co-Responder Team Model, at least one law enforcement officer and one mental health professional jointly respond to situations that likely involve a behavioral health crisis. A co-responder team can de-escalate situations and promote diversion to services. Some communities, such as Douglas County, Colorado, have created youth-specific co-responder teams with special training in responding to youth behavioral health crises. Their Youth Community Response Team partners with law enforcement, Fire/EMS, and mental health providers, and they cover all public, private, and charter schools in the areas.

### BEST PRACTICE: DEVELOP COMPREHENSIVE DELINQUENCY PREVENTION

Strategies that are aimed at reducing the risk of juvenile referral focus on protective factors that keep kids safe, mentally healthy, and on track in school. It is important to recognize that delinquency arises when youth are exposed to a multitude of risk factors in their families and environments.

A comprehensive strategy focuses on increasing youth academic achievement and positive parental relationships. Additionally, pairing youth with mentors has been demonstrated to prevent delinquency. Years of evidence has shown that positive role models dramatically improve youth outcomes, even for youth with significant mental and emotional health issues. There is no single program that can accomplish these goals. A comprehensive prevention strategy involves multiple approaches that are tailored to individual youth. It is imperative that schools, parents, and police all recognize that prevention works best in conjunction with intentional efforts to build resilience, involve youth, and see the best in them.

## BEST PRACTICE: DISABILITY AWARENESS TRAINING FOR LAW ENFORCEMENT

The Arc National Center on Criminal Justice & Disability partners with law enforcement across the country to increase awareness and provide learning resources on intellectual and developmental disabilities (IDD). People with IDD often have limitations in intellectual functioning and adaptive behaviors such as social, practical, and conceptual skills. The most common diagnoses include autism, Down syndrome, Fragile X syndrome, and Fetal Alcohol Spectrum Disorder. Not every person with a developmental disability has an intellectual disability.

Often there are no outward signs that an individual has IDD, and the officer might misinterpret behavior that is related to their diagnosis as suspicious. When confronted, people with IDD often react with fear, thus reinforcing officer suspicion. The interaction can then cascade, with the person with IDD running away from the officer, stimming (hand flapping, rocking, spinning, or repetition of words or phrases), not following commands, or not looking at the officer's face.

Often people with IDD will not understand the officer and, out of fear, pretend to understand or quickly admit to committing a crime. Also, when the person with IDD has been the victim of a crime, their interactions with police cause them increased fear and distress, making them hesitant or unclear in describing what happened to them. For these reasons, it is imperative that law enforcement receive special training about IDD.

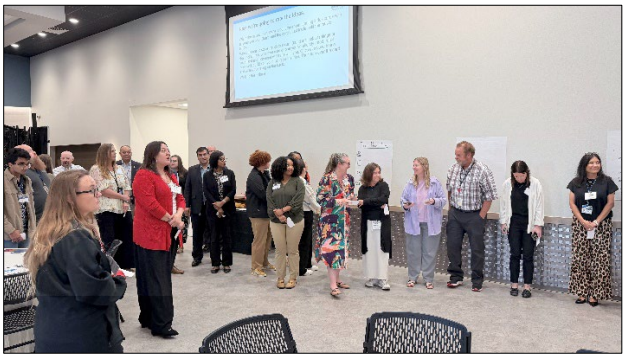
Some of the techniques recommended by The Arc include:

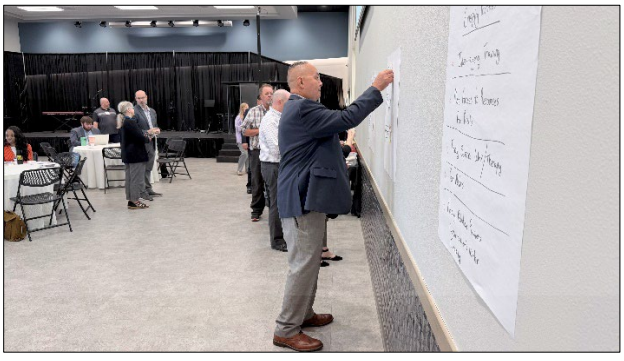
1. Making a personal connection as quickly as possible. Help them feel safe. Listen to the individual's family or caregivers for tips on how to calm them down. If a youth does run away, consider why they might be afraid.

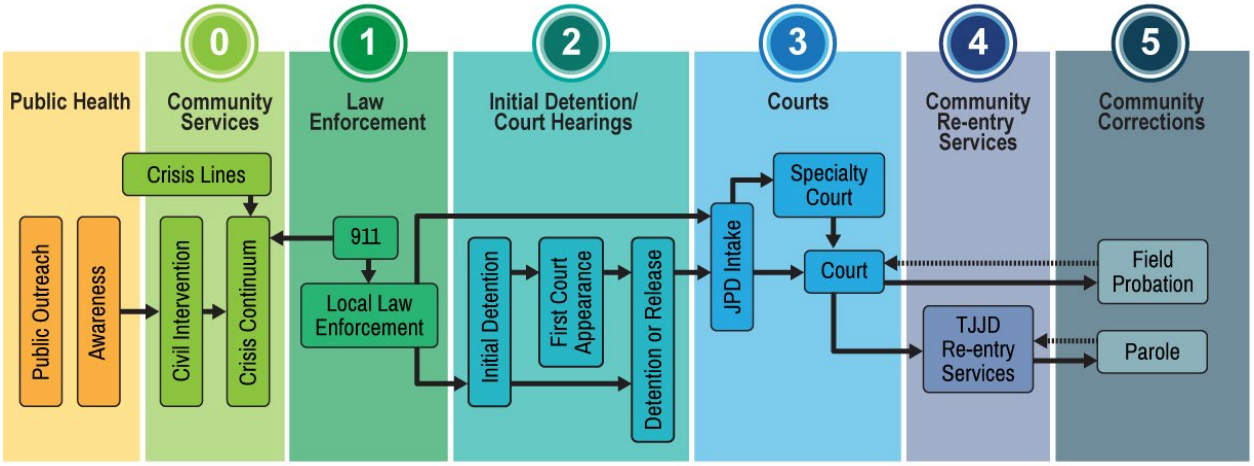
2. Recognize that stimming helps the person with IDD to calm down. Give them space before attempting to make a personal connection. Recognize that the individual may communicate in unexpected ways.
3. If the individual does not immediately follow commands, make sure they understand. Wait at least 7 seconds for the information to be processed. Ask the person to repeat the direction or command in their own words. The officer can also physically demonstrate what they'd like the person to do.
4. Don't assume that a lack of eye contact is disrespect. This may be a typical response for someone with IDD.
5. When there is suspicion of a law violation, ask the person to repeat back what the officer said, especially when reading their Miranda rights. Ensure that the person has an attorney or another support person to advocate for them.
6. When there is suspicion that the individual with IDD is a victim of a crime, ask them what would help them feel safe. Let them know you believe them. Get them to tell their story in their own way and in their own time. Recognize that trauma will make it especially difficult for a person with IDD to communicate.

## BEST PRACTICE: FIRST OFFENDER PROGRAMS

The Judicial Commission on Mental Health's "Texas Juvenile Mental Health and Intellectual Disabilities Law Bench Book" (2023 – 2025), p. 52, describes law enforcement's statutory discretion to divert youth from juvenile justice referral and instead address law violations through First Offender Programs.








## INTERCEPT 2

**Intercept 2** encompasses youth who are detained and have a detention hearing. This intercept is the first opportunity for judicial interaction in the juvenile justice system, including intake screening, early assessment, appointment of counsel and pretrial release of youth with mental illness, substance use disorder, or intellectual and developmental disabilities.

## INTERCEPT 2 RESOURCES

| Intercept 2<br>Pretrial/Detention | |
|---|---|
| **Assessments**<br>Standardized intake/assessment process used across TTUHSC programs to ensure consistent information and referrals.<br><br>LCJJC staff or contracted staff (LPC, LCSW) conduct assessments. | **Programming**<br>Therapy groups, individual sessions, RTCs, Psychiatry, Medication Management, Social Worker, Case Manager |
| Multisystemic Therapy (StarCare) | |

## INTERCEPT 2 GAPS AND OPPORTUNITIES

Stakeholders at Intercept 2 identified several gaps in the early stages of court involvement, including lagging communication during arrest and detention, delays in behavioral health assessments, and insufficient psychiatric services prior to adjudication. According to some

participations, families often feel frustrated or unprepared for the adjudication process. Also, some participants noted a general lack of clarity about decision-making and outcomes.

The community recognized that these challenges create opportunities to perform behavioral assessments and provide psychiatric services earlier in the adjudication process. They also saw an opportunity to build family systems approaches into court processes, orienting parents to the process and fostering engagement throughout. They also saw opportunities to engage community volunteers to support youth and families, especially youth co-involved with the child-protection system.

Identified Gaps:

- Lag in communication during and after arrest
- Behavioral assessments occurring too late (after detention hearings)
- Delays in notification of youth release from detention
- Lack of specialized services for youth with high behavioral needs
- Limited discretionary placements at JJAEP
- Lack of clarity in adjudication decisions
- Family frustration with booking and release process
- Insufficient documentation and coordination between courts and schools
- Shortage of local beds for detained youth

Opportunities for Innovation:

- Behavioral assessments conducted earlier in detention process
- Pre-adjudication psychiatric services
- Parent education and orientation on the adjudication process
- Implementation of drug courts and aftercare supports
- Expansion of family systems therapy and involvement
- Recruitment of more CASA volunteers
- Early linkage to community-based services before formal supervision

## INTERCEPT 2 BEST PRACTICES

### BEST PRACTICE: COLLABORATION BETWEEN LOCAL SCHOOLS AND JUVENILE DETENTION

Collaboration between schools and juvenile services is essential to maintain educational continuity and support academic progress of youth. Some key best practices include:

1. Information Sharing: Develop formal agreements to facilitate the secure and legal exchange of educational records between schools and juvenile detention.
2. Coordinated Lesson Planning:
    a. Align curricula inside juvenile detention with local school curricula.
    b. Provide joint training session for educators from both settings to share effective teaching techniques and address the unique needs of detained youth.
3. Monitor Academic Progress
    a. Create individualized education plans for students with special needs, to ensure they receive the appropriate support and accommodations in juvenile detention and in local schools.
    b. Implement ongoing assessments to monitor academic progress.
4. Transition Supports
    a. Begin planning for the youth's transition from detention back to school upon entry into the detention center. Involve the child's educators, counselors, and family members.
    b. Provide mentorship to youth as they transition back to school.

### BEST PRACTICE: ENSURE PRESUMPTION OF RELEASE

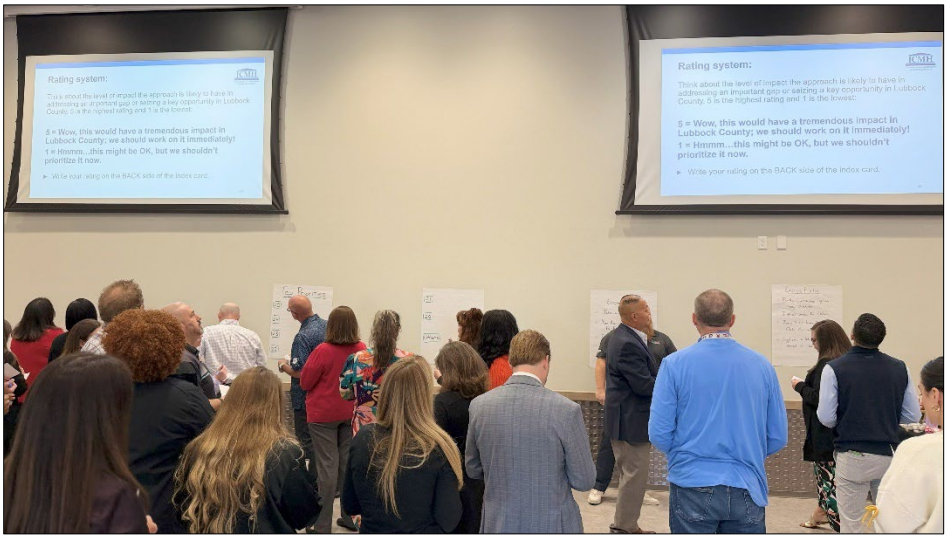
According to state law (Tex. Fam. Code § 54.01(e)), it is presumed that a youth will be released from detention except under certain circumstances such as:

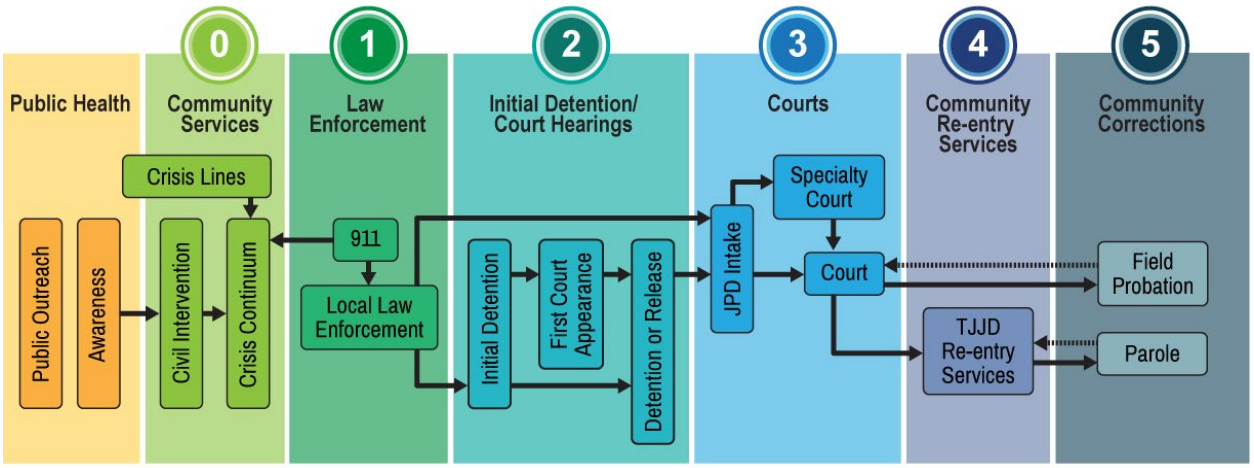
- Risk that the child might abscond,
- Unsuitable supervision,
- Lack of a parent or caregiver to whom the court can release the child,
- A risk of harm to self or others, or
- Previous delinquent conduct.

Most of these conditions can be resolved when the child's mental and behavioral health challenges can be addressed quickly, and the child can be safely returned home to their family or

caregiver. As described previously, a comprehensive strategy does not look solely at finding an alternative placement but also addresses the comprehensive needs that keep kids at risk when returned to home following release from detention.

For instance, juvenile probation could work collaboratively with a local mental health authority or other community service provider to mobilize wraparound case management for the child and family. A county might utilize short term respite centers for youth. Alternatively, they might pair family members with a certified family partner who has similar lived experience. They might also engage inpatient or therapeutic group homes. When the focus is on bolstering protective factors for the child or family, releasing the child from detention can also decrease the likelihood of future juvenile involvement.






## INTERCEPT 3

**Intercept 3** involves the supports and approaches within courts that influence the future path for juvenile justice-involved youth with mental health needs and intellectual and developmental disabilities. These approaches encompass trauma-informed courtrooms, specialty courts, and specialized training for judges, defense attorneys, prosecutors, and court personnel.

## INTERCEPT 3 RESOURCES

| Intercept 3<br>Courts | |
|---|---|
| The Honorable Stephen L. Johnson<br>Associate Judge | **Court Magistrate**<br>The Honorable Melissa Jo McNamara |
| **Child Protection Courts**<br>The Honorable Kara Darnell<br>The Honorable Meg Jordan<br>The Honorable Shelly Marshall<br>The Honorable Kelley Tesch | **Child Support Court**<br>The Honorable Shelly Marshall Presiding |
| **Justice of Peace Courts**<br>**Address Juvenile and Minor Offenses:**<br>Alcohol Violations, Shoplifting, Traffic Violations, Truancy, and Tobacco Violations | **Lubbock Teen Court**<br>Municipal Judge Meryl Benham |

**Building a More Responsive Justice System**

In Lubbock County, Judge Melissa McNamara serves as magistrate at a critical point where young people often meet the justice system for the first time. Overseeing juvenile detention and plea dockets, she brings both structure and care to her role, recognizing that accountability and opportunity must go hand in hand if outcomes are to change.

Under Judge McNamara's leadership, Lubbock County now conducts behavioral health assessments for every youth entering detention — a shift that ensures decisions are informed by a fuller understanding of each young person's needs. These assessments have become a cornerstone of the county's juvenile approach, helping match youth to mental health services, evaluations, and community supports that can redirect their path.

Looking ahead, Judge McNamara sees the work continuing toward a more connected and responsive local network — one where assessments lead quickly to action, and where partners like Texas Tech are integral to ensuring timely, effective support. Her focus is on building systems that respond as swiftly as the courts do, so that help reaches young people when it can still make the greatest difference.

For Judge McNamara, progress in juvenile justice is measured not only by reduced recidivism, but by how quickly and effectively the community comes together when a young person needs support.

## INTERCEPT 3 GAPS AND OPPORTUNITIES

At Intercept 3, the community recognized that communication breakdowns across agencies hinder youth progress through the system. Stakeholders reported inconsistent documentation and a lack of shared systems for information exchange. The process of adjudication was described as lengthy and burdensome for both youth and families. Participants also cited a lack of local behavioral health placements for Lubbock County youth, forcing families to seek care outside the region.

Community members saw these challenges as opportunities to strengthen collaboration and build a more responsive system. They emphasized the need to professionalize and expand the workforce, provide site-based training to support staff retention, and create structured, ongoing coordination among juvenile justice partners. Developing individualized transition plans that help

each youth successfully reintegrate into school and community settings was seen as an important next step.

Identified Gaps:

- Limited communication between agencies and systems
- Lengthy adjudication processes
- Inadequate documentation and data sharing
- Shortage of behavioral health placements for youth
- Workforce shortages and limited specialized training

Opportunities for Innovation:

- Site-based training to recruit and retain specialized staff
- Development of a centralized communication or case management system
- Data-driven collaboration among justice and behavioral health partners
- Personalized transition plans for each youth
- Expansion of training and education opportunities for juvenile justice professionals

## INTERCEPT 3 BEST PRACTICES

### BEST PRACTICE: FAMILY ENGAGEMENT IN JUVENILE COURT

It is imperative that families are engaged in the juvenile court process to produce positive outcomes for youth. They are the most important factors in promoting positive behavior and skill building. Promoting positive family engagement is associated with optimal mental health outcomes, school achievement, and positive peer relationships.

Most communities struggle to engage families effectively. It is not uncommon for courts and probation staff to become more directive, considering ways to require families to remain involved, which makes partnering with the family to create optimal outcomes a challenge. Sometimes courts have no clear way of promoting family engagement throughout the process.

Courts might consider shaping their family engagement strategies as follows:

- Recognize how juvenile court obligations impact the functioning of a family that already struggles with its own behavioral health and logistical challenges,

- Develop interventions based on the capacities and needs of family members who would be responsible for ensuring their child remains engaged,
- Seek out evidence-based models that divert children from detention and keep them with their families as far as possible, and
- Establishing measurable objectives regarding positive family engagement and collecting data to track outcomes.

Additionally, courts and juvenile probation offices might consider creating more formal partnerships with families of justice-involved youth. For instance, the Juvenile Probation Department of Pierce County, Washington, established a family council to assist the court and probation in shifting toward a family-centered approach. The Department of Youth Services in Massachusetts established virtual family counseling services to help families address their unique needs rather than create a single program or class that may or may not address family needs. The Department also hired a Director of Family Engagement to work with families and ensure that the court best partners with families as the experts. Montana developed a family mentoring program, pairing parents with family partners.

In Williamson County, Texas, the Juvenile Probation Department excels at parent and family engagement. In support of their goals, they have recruited community members and businesses to provide treats, experiences, and accessible events for families whose children are involved in the juvenile justice system.

These are just a few examples of successful approaches to family engagement.

### BEST PRACTICE: STREAMLINED FITNESS RESTORATION PROCESS

According to Texas Health and Human Services, a streamlined process of fitness restoration might include:

- Continuity of care for youth found unfit to proceed,
- Regular review of fitness restoration cases across juvenile justice and local mental health authority stakeholders,
- Outpatient fitness restoration, and
- Regular trainings and education to courts on Family Code Chapter 55, which relates to proceedings concerning children with mental illness or intellectual disabilities.

The Judicial Commission on Mental Health also outlines best practices for reviewing fitness reports, which include:

- Ensure that attorneys who receive the child's fitness report understand it and determine whether it is an accurate portrayal of the child.
- Question whether the language attributed to the child matches the lawyer's own observations.
- Be aware of descriptions such as those listed below, which may indicate that the child is not currently fit to proceed, even if fitness reports might say otherwise:
    - "The child appears at least marginally fit to proceed at this time."
    - "The child's cognitive functioning is within the borderline range, but their adaptive behavioral functioning is noticeably below expectation."
    - "The child was partially oriented to time."
    - "The child did not know the name of the home where they were living."
    - "The child's communication was rated within the severely impaired range."
- Understand that children are either fit to proceed or not, there is no "sliding scale" of fitness. It might be necessary for attorneys to object to fitness determinations that are based on a "partially fit" assessment.
- Speak to the child at least by phone prior to determining whether to object to the report, and to request additional time.

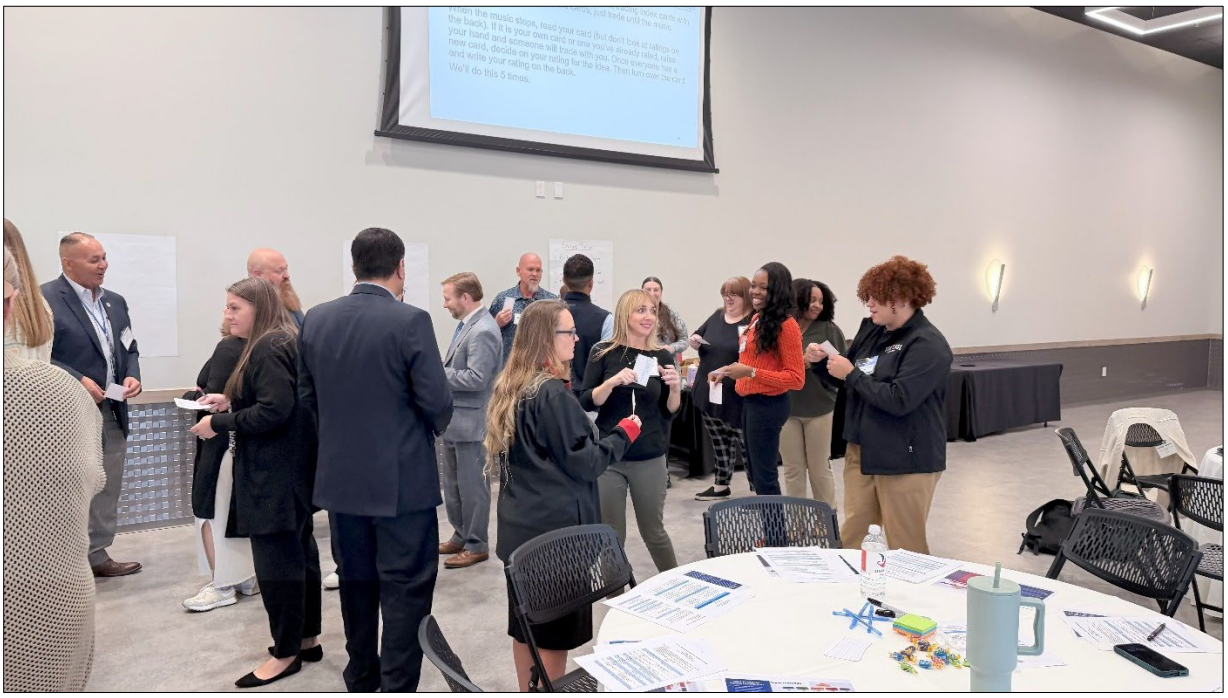
## BEST PRACTICE: TRAUMA-INFORMED JUVENILE COURT SYSTEMS

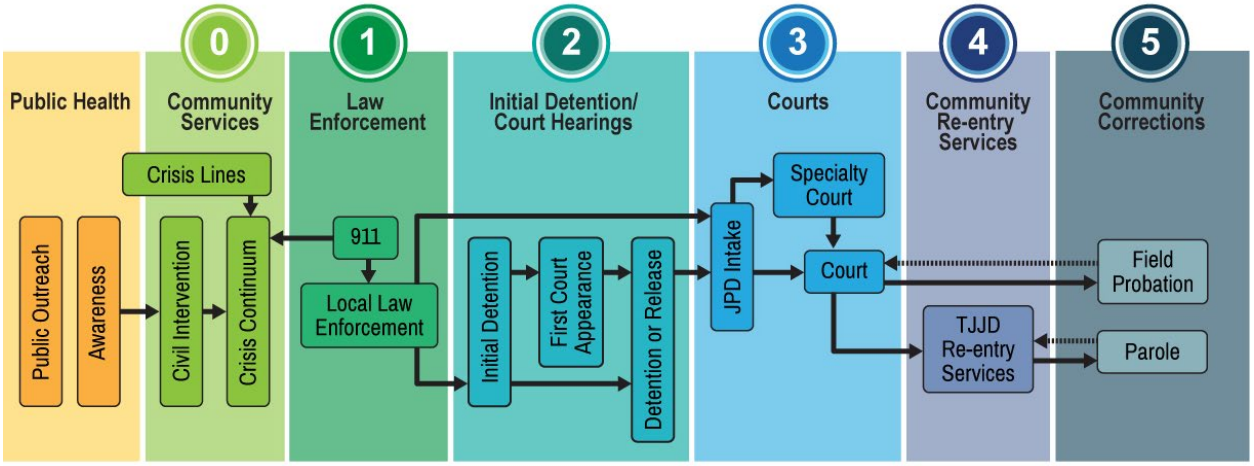
According to the National Child Traumatic Stress Network, more than 80 percent of juvenile justice-involved youth report having experienced trauma with many of them having experienced multiple, chronic, and pervasive personal trauma. It is imperative that juvenile courts and staff of organizations that serve justice-involved youth receive training on trauma and to adopt trauma-informed practices to protect children.

Some of the applicable principles include:

- Creating a culture of trauma-informed care,
- Collaboration within and across systems,
- Respect for youth and family voice,
- Recognize and address the potential for secondary trauma, or the trauma that occurs when working with and serving youth with experiences of trauma, among court and probation staff,

- Providing ongoing quality training,
- Promote information sharing between entities to spark innovation and harness best practices,
- Establish a training system informed by data, and
- Ensure that training is adequately funded and sustainable.




## INTERCEPT 4

**Intercept 4** encompasses youth who are transitioning from juvenile detention or state custody. Services in this intercept include those that will address risk factors that increase the likelihood of future juvenile justice involvement as well as resources that help to bolster protective factors—such as family stability, positive peer group, and vocational training—that help a child with behavioral health challenges transition back into school and the community.

## INTERCEPT 4 RESOURCES

| Intercept 4<br>Reentry | |
|---|---|
| TCOOMMI Continuity of Care | Community Resource Coordination Group (CRCG) |
| Workforce Solutions South Plains | Open Door LBK |
| Catholic Charities of Lubbock Kinship Program | Parent Empowerment Program (PEP) |
| The Salvation Army Texas South Plains | Community Advocacy Project for Students (CAPS) |
| TJJD Halfway Houses | |

## INTERCEPT 4 GAPS AND OPPORTUNITIES

Stakeholders highlighted gaps in reentry coordination, particularly around continuity of care for youth leaving detention. Many young people reentered schools and communities without consistent access to mental health services or wraparound supports. The community noted that peer mentorship and pre-release planning were underdeveloped, and that more collaboration was needed between probation, StarCare, and community-based providers.

Participants saw this as an opportunity to expand peer mentor programs. They also suggested conducting pre-release intake assessments with StarCare. Participants also saw an opportunity to provide training for families and educators to support reintegration. Increased funding for intensive case management and inpatient juvenile programs was also emphasized.

Identified Gaps:

- Fragmented access to ongoing mental health care through LMHA
- Lack of peer mentors for reentry support
- No formal pre-release assessment processes
- Shortage of inpatient juvenile programs
- Limited funding for wraparound and intensive case management services

Opportunities for Innovation:

- Streamlined access to LMHA services
- Establishment of peer mentorship programs
- Development of pre-release intake assessments with LMHA
- Increased training for reentry and education staff
- Expanded funding for inpatient and wraparound services

## INTERCEPT 4 BEST PRACTICES

### BEST PRACTICE: START REENTRY PLANNING UPON JUVENILE REFERRAL

According to the Justice Center of the Council on State Governments, the most effective reentry planning occurs when the planning begins at intake and continues through family reintegration and aftercare. Successful outcomes require case management that begins with the end in mind: resilient children bolstered by protective factors within their families and communities. This

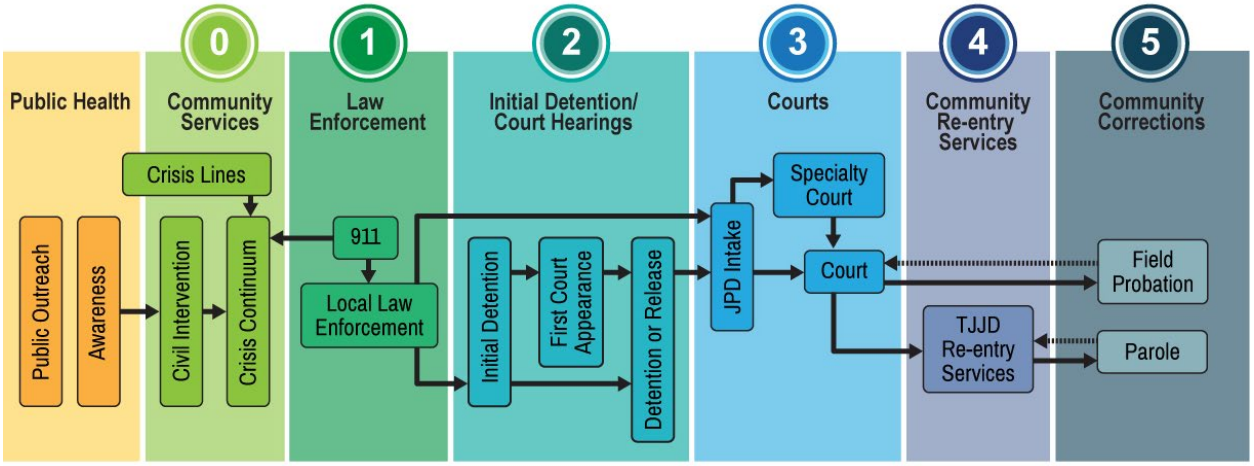
requires the juvenile probation department to work with case managers within the community to identify the risk factors that must be addressed to achieve successful reentry. A flexible and individualized approach is most likely to achieve success.

## BEST PRACTICE: SCHOOL TRANSITION

Justice-involved youth are at high risk of falling behind their peers, forcing them to repeat grades and increasing the likelihood they drop out of school entirely. State law (Texas Education Code § 37.023) requires that all returning students have a transition plan, but many districts are either unaware of these obligations or they lack the training and guidance to do transition planning effectively. As an additional support, the Texas Legislature passed H.B. 5195 in 2023, which added section 54.021 to the Texas Family Code to ensure that youth in detention facilities receive education and services while detained. By the 21st day of a youth's detention, the detention facility must assess the child and develop a written plan to reach rehabilitation goals and provide a status report every 90 days.

Recommendations for improving transition planning include:

- Utilize a team-based approach to school transition, including family, school, juvenile probation, and community providers such as local mental health authorities,
- Foster efficient records transfer from juvenile detention to schools, also ensuring that education services within juvenile detention are aligned with ISD curriculum requirements,
- Develop an individualized transition plan that accounts for the unique needs and challenges of family members as well as youth,
- Stay up to date on relevant research, especially when developing individualized interventions, and
- Perform regular monitoring and tracking.




INTERCEPT 5

**Intercept 5** encompasses youth under juvenile justice community supervision. This intercept combines youth programming and youth/family service coordination to provide the supports necessary to help youth with behavioral health needs succeed.

## INTERCEPT 5 RESOURCES

| Intercept 5<br>Community Supervision | |
|---|---|
| Juvenile Probation | Lubbock County Juvenile Justice Center |
| Mentor Programs | StarCare Specialty Health System (LMHA) |

## INTERCEPT 5 GAPS AND OPPORTUNITIES

At the community supervision stage, participants described persistent challenges in accessing community resources for youth. Providers were often physically distant from neighborhoods most in need, and funding limitations continued to constrain program availability. Stakeholders emphasized that even after reentry, many families lacked adequate support for youth with ongoing behavioral health needs.

The community identified these barriers as opportunities to expand build local capacity and increase the number of providers within communities, especially providers accepting Medicaid. By situating services closer to youth, Lubbock County can strengthen long-term outcomes for youth on probation or under community supervision.

Identified Gaps:

- Providers not located within accessible community settings
- Ongoing funding shortages
- Limited availability of training and education for providers

Opportunities for Innovation:

- Placing providers closer to the neighborhoods they serve
- Expanding community-based training and professional development
- Increased funding for sustainable youth and family supports

## INTERCEPT 5 BEST PRACTICES

### BEST PRACTICE: DEVELOP A COMMUNITY APPROACH TO JUVENILE PROBATION

Many of the best practices already mentioned in this report, including wraparound case management, family engagement, and reentry planning, all serve to improve probation outcomes. In a rural area with limited resources, juvenile probation departments may lack the internal resources and community services that might be available in larger cities. This requires courts and probation departments in smaller counties to reimagine how probation can best partner with local mental health authorities, schools, CRCGs, and other community resources to achieve best outcomes. Juvenile probation does not have to be in it alone.

For instance, when probation partners with schools to ensure youth with mental health, learning, or developmental disorders receive the proper educational supports, they can achieve better educational outcomes. As an example, Disability Rights Texas partners with the Harris County Juvenile Probation Department to assist them in advocating for special educational services and accommodations.

Juvenile probation departments in smaller areas might also consider using certified peers with relevant lived experience to work alongside youth with mental and emotional health challenges and certified family partners to work with families. Departments could also recruit mentors and other volunteers to assist with positive youth development.

Juvenile probation departments might also consider partnering with a workforce development board or other vocational resources to establish training and job preparation programs for youth

on probation. The Annie E Casey Foundation provides a number of examples across the country of successful workforce/probation partnerships.

There are just a few examples of partnerships that can help smaller counties achieve optimal juvenile probation outcomes.

## BEST PRACTICE: FAMILY ENGAGEMENT IN JUVENILE SERVICES AND PROBATION

Lubbock County Juvenile Justice Department dedicates officers to family engagement and youth transition back to home and the community. As the community works toward implementing its family engagement strategy, team leaders might benefit from considering how family engagement approaches are changing. The Annie E. Casey Foundation offers strategies for shifting practices and thinking around family engagement:

1. Make youth and family partnerships a key priority
2. Ensure that the term "family" encompass parents as well as other family caregivers,
3. Simplify language that juvenile professionals use,
4. Involve youth and families in case planning,
5. Look broadly at the needs of youth and families, encompassing everything from reducing transportation barriers to connecting youth with recreational activities,
6. Provide ongoing training to probation staff and partners, ensuring that they are always on the leading edge of emerging best practices, and
7. Engage youth and families in efforts to improve the overall juvenile system for everyone, including future clients.

## BEST PRACTICE: CERTIFIED FAMILY PARTNERS SUPPORTING FAMILIES OF JUVENILE JUSTICE-INVOLVED YOUTH

A consistent body of research shows that meaningful family engagement is one of the strongest predictors of positive outcomes for youth involved in the juvenile justice system. Yet studies consistently find that families often experience shame, confusion, and mistrust when navigating courts, probation, mental health services, and schools. All of these are factors that significantly reduce participation in programs, such as juvenile probation, that rely on parental involvement.

Certified Family Partners (CFPs), who combine professional training with their lived experience raising a child with behavioral health challenges, are uniquely positioned to address these

barriers. Their training, expertise in navigating complex juvenile justice and mental health systems, and commitment to trauma-informed approaches equips them to provide emotional support and build confidence. Their direct support to families helps grow caregiver self-efficacy - their internal sense that they can succeed as a parent. All of these are the key conditions for improving family participation.

Preliminary studies indicate that CFPs may contribute directly to outcomes associated with reduced recidivism, improvements in child engagement with juvenile and mental health programming, and overall improved family functioning. For instance, a parent-to-parent program in King County, Washington demonstrated positive effects for parents involved in the child-welfare system. In another study, families receiving Family Partner services reported an increase in parental self-efficacy, strengthened relationships with system partners, and reduced feelings of isolation and blame.

Certified Family Partners can reinforce the core principles of evidence-based family interventions such as multi-systemic therapy (MST) by helping parents build motivation, navigate services, follow through on plans, and advocate effectively for their children. Overall, there are good reasons to think that incorporating Certified Family Partners into juvenile justice will measurably improve outcomes for both youth and their caregivers.


## PRIORITIES FOR CHANGE

Following the discussion on gaps and opportunities, the participants brainstormed priorities that might address gaps and help the community seize opportunities. They produced dozens of suggestions. They were then asked to rate the priorities on a one-five scale:

5 = Idea would have tremendous impact, and we should work on it immediately
1= Might be a good idea, but not a high priority at this time

After five rounds of community members reading and rating the ideas, participants identified a list of high/immediate, moderate/near future, and priorities for later.

| **Lubbock County Youth SIM Priorities** | |
|---|---|
| High/Immediate | Local Inpatient Services for Children |
| | Resource Awareness and Identification |
| | Case Management Across All Intercepts |
| | Regular Stakeholder Meetings to Enhance Communication |
| Moderate/Near Future | Interagency Communication to Reduce Duplication |
| | Supporting Community Programs at Intercept 0 and in Schools |
| | Child Clinician Available to MCOT Teams |
| Priorities for Later | Increase Availability of Affordable Therapists |
| | Better Organized Referral/Navigatioin |
| | Peer Mentors |
| | Placing Probation Providers Closer to Clients |

Importantly, nearly every participant rated the need for inpatient services for children as the highest and most urgent priority. Participants learned that the County is well along in the process of creating inpatient services, with some funding identified already. The County anticipates opening inpatient services for youth as early as 2027.

Satisfied that there is sufficient effort already dedicated to creating inpatient services, the participants turned their attention to the remaining priorities. Participants were given three adhesive dots to vote for their top priorities. They wrote their initials on the ideas that they were willing to give their time and effort to make a reality in Lubbock County. At the end of this process, four key priorities emerged.

**Priority 1:** Community Resource Awareness and Identification

**Priority 2:** Expand Prevention and Intervention School Programming

**Priority 3:** Expand Juvenile Probation Staff and Youth Prevention / Intervention Programs

**Priority 4:** Create Seamless Person-Centered Community Resource Center

# ACTION PLANS

Workshop participants were invited to join one of the four priority groups to create an action plan. Each team developed a plan with objectives and near/long term tasks. Afterwards, each group reviewed the plans developed by other teams. All participants were encouraged to make suggestions and raise considerations for these plans, thereby helping each team to improve upon the plans. The teams identified a time and date for their next meetings, as well as champions to coordinate communication among team members.

The purpose of the action planning activity was to create a site-specific action plan with clearly defined, attainable, prioritized short-term and long-term steps addressing the gaps identified during the workshop. The plans will be further refined and implemented by each team following the workshop.

The action plans on the following pages are the initial drafts developed during the workshop. The teams have already made specific plans to continue meeting, so these drafts will not reflect the work done after the workshop and prior to the publication date of this report. Readers should contact team members for the most current information on these action priorities.

## PRIORITY 1: COMMUNITY RESOURCE AWARENESS AND IDENTIFICATION

*Our priority is to create a comprehensive tool for families and providers to help navigate to appropriate services before a crisis.*

Priority champion: Sabrina Marcum

### OBJECTIVES:

- Creating a tangible tool and interface to identify appropriate resources.
- Make navigation as easy as possible for families and providers.
- Ensure families utilize services.

### TASKS:

- Determine what resource lists/tools/apps are already available and consolidate.
    - Determine what's missing.
    - Identify who to contact/funding/eligibility.
- Adapt tool for provider interface/family utilization.
- Market the tool/quarterly meetings.
- Boost resource awareness by including on school websites, etc.
- Utilize tool during various assessments and connecting families with resources when needs are identified. (Early ID)
- Normalize resource utilization for families.

### FEEDBACK:

- Does every family have a way to access the internet and technology?
- How would you keep the resources up to date?
    - Regular (quarterly) updates to interface
- Message me chatbox
- Multiple languages for resources (emphasize main language in Lubbock)
- Expanding this to community resource locations (churches, supermarkets, library, YWCA).
- Catholic Charities has a guide for community resources (not just mental health).
- Utilize QR Codes
- Multiple media platforms (Facebook, Instagram, etc.)
- Adapt for police response

- How are the Child Psychiatry Access Network (CPAN) and Perinatal Psychiatry Access Network (PeriPAN) services incorporated here?
- How is Outreach, Screening, Assessment & Referral (OSAR) incorporated here?
- Is this specific to Lubbock County? Some organizations cover surrounding counties.
- Include family medicine and pediatrics with well-child screenings
- User-friendly interface
    - Easily navigate to appropriate resources
    - Resources tailored to specific problems/concerns

Next meeting: ***Thursday, November 13th at 12:00pm on MS Teams***

## RESEARCH AND PRACTICES RELATED TO PRIORITY ONE

Earlier sections of this report discuss best practices along the SIM continuum. With respect to Priority 1, the priority planning team might benefit from considering these relevant best practices:

- Intensive Care Coordination
- Foster Early Identification and Intervention
- Mental Health and Juvenile Justice Interagency Collaboration

## PRIORITY 2: CASE MANAGEMENT ACROSS ALL INTERCEPTS

*Our priority is to understand the resources a youth might need and ensure the information flows across systems.*

Priority champions: Bailey Hagler and Dr. Sarah Wakefield

### OBJECTIVES:

- Boost awareness of Community Resource Coordination Groups (CRCG) and referral process.
- Improve collaboration and communication among case management staff.
- Develop common electronic Release of Information (ROI)/consent across entities.
- Advocate at the state level when needed.

### TASKS:

- Boost awareness of CRCG and referral process.
    - StarCare with help (Bailey)
    - Present to relevant groups (e.g. Interdisciplinary Team)
    - Improve collaboration and communication among case management staff (SPED services, StarCare, Foster care, Relational Health Center).
    - Get buy-in from leaders (Nancy).
    - Have case management staff meet periodically.
- Develop common electronic ROI/consent across entities.
    - Gather current forms (Nancy).
    - Review forms to identify overlap and differences (full group).
    - Draft proposed common form.
    - Have attorneys review.
    - Common intake process (future)
    - Electronic passport (future)
- Advocate at the state level when needed.
    - Bring needs to Texas Child Healthcare Consortium

### FEEDBACK:

- Resource: Voice of Hope youth advocates/care management/care coordinator
    - Mary and Cherry
- Other potential case management
    - St. Francis Ministries
    - Texas Boys and Girls Club
- Texas Child Health Access Through Telemedicine (TCHATT) Case Management

- Recovery peers, certified family partners, and MH peers are a great thing to incorporate here.
- How would forms be disseminated and explained to families?
- Consider the need for MOU/contact.
- Who is in charge of drafting a common ROI?
- What is the case manager's scope/responsibility in each agency?
- Will there be one centralized case management entity? (Right now, it's just coordinated.)
- Can one ROI/consent cover all entities/agencies/needs?
- Love to hear current legislative gaps and ideas for future policies.

Next meeting: ***TBD, will coordinate electronically with Dr. Nancy Trevino.***

## RESEARCH AND PRACTICES RELATED TO PRIORITY TWO

Earlier sections of this report discuss best practices along the SIM continuum. With respect to Priority 2, the priority planning team might benefit from considering these relevant best practices:

- Intensive Care Coordination
- Foster Early Identification and Intervention
- Mental Health and Juvenile Justice Interagency Collaboration

## PRIORITY 3: COMMUNITY & SCHOOL-BASED IDENTIFICATION PROGRAM

*Our priority is to provide individuals and institutions with reliable and accurate information.*

Priority champions: Kendra Cates and Amanda Vieregge

**OBJECTIVES:**

- Connect families effectively to StarCare and other services for both IDD and MH issues, centering family decision making and information accessibility.
- Provide appropriate training and education for different types of educators and professionals.
- Implement mechanisms for information sharing, where appropriate.

**TASKS:**

- Provide appropriate resources at all 504 and ARD meetings.
    - QR code with centralized list of services and resources.
- Consider and determine appropriate training for various groups.
    - Distinguish between behavior and MH issues.
- Discover barriers to information sharing.
- Include all school types and sizes.

**FEEDBACK:**

- Sounds like a tangible step 2 to Priority 1's objective. Could this be a collaboration?
- Maybe also a physical list of resources to increase accessibility.
- New requirement for IDD from schools.
- Consider trainings already in place for MTSS and school systems for identification of student needs (Student Success Team (SST), 504, SPED, PBIS).
- How do Child Psychiatry Access Network (CPAN) and Perinatal Psychiatry Access Network (PeriPAN) interact here?
- Texas Tech Mental Health Initiative (TTMHI) (via Priority 4: West Texas MH Collab) can host website and resource lists.
- Create a common ROI between schools and MH entities.
- Is there extra assistance for families that may need help accessing service?
- Follow up to ensure connection.
- Behavioral and MH issues barriers
- This links perfectly w/case management and ROI database/system.
- Love to hear current legislative gaps and ideas for future policies.

Next meeting: ***Friday, November 14 at 12:00pm on Zoom*** (Lacey Gordon will send the link)

## RESEARCH AND PRACTICES RELATED TO PRIORITY THREE

Earlier sections of this report discuss best practices along the SIM continuum. With respect to Priority 3, the priority planning team might benefit from considering these relevant best practices:

- Mental Health and Juvenile Justice Interagency Collaboration
- Comprehensive Delinquency Prevention
- Collaboration Between Local Schools and Juvenile Detention
- Start Reentry Planning Upon Juvenile Referral
- Develop Community Approach to Juvenile Probation
- Family Engagement in Juvenile Service and Probation

## *PRIORITY 4: WEST TEXAS MENTAL HEALTH COLLABORATIVE CHILD AND FAMILY SUBCOMMITTEE*

*Our priority is to coordinate the work that grew out of the Youth SIM and ensure that it evolves and moves forward in conjunction with the West Texas Mental Health Collaborative.*

Priority champions: Ginny Simpson and Dr. Nancy Trevino

**OBJECTIVES:**

- Collaborative communication between groups for policy and infrastructure development.
- Service Coordination
- Funding
- Community advocacy and education
- Engagement of community members and organizations

**TASKS:**

- Identify and engage/invite relevant stakeholders.
- Schedule preliminary planning meeting.
- Develop an agenda for the first meeting.
- Host the first meeting in January 2026.
- Designate regularly scheduled meetings by membership.
- Needs assessment update: Processes/Services/Gaps
- Prepare for legislative session/policy
- Grant committee
    - Explore current/upcoming grant opportunities
- Identify existing education and training and opportunities for expansion.
- Connect with resources groups
    - Community Resource Coordination Group (CRCG) - Ruby V.
    - Children's Advocacy Center - Derek D.
- Consider regional opportunities

**FEEDBACK:**

- Identify policy barriers and areas for advocacy.
- Identify existing education disparities and expansion.
- Love to hear current legislative gaps and ideas for future policies.
- Contingency plan with federal changes trickling down to the state level.

Next meeting: ***Thursday, November 13 at 1PM on Zoom***

## RESEARCH AND PRACTICES RELATED TO PRIORITY FOUR

Earlier sections of this report discuss best practices along the SIM continuum. With respect to Priority 4, the priority planning team might benefit from considering these relevant best practices:

- Mental Health and Juvenile Justice Interagency Collaboration

# RECOMMENDED NEXT STEPS

The Youth SIM Mapping process serves as a springboard to continued and enduring collaboration between stakeholders across all intercepts. To create the systemic changes outlined in the Lubbock County goals, a whole community approach is required. To ensure that the community stays engaged, the following next steps are highly recommended.

## STRENGTHEN ACTION TEAM PLANNING

The most effective way to make progress and increase communitywide motivation is through action planning. During the in-person workshop, Lubbock County created four priority teams as well as priority champions. These key stakeholders are responsible for moving the action plans forward. To ensure continued momentum:

1. **Clarify the Role of Priority Champions:** These individuals assume responsibility for scheduling meetings, tracking commitments, checking on progress, and overseeing the various tasks associated with the action plan. This does not mean that the priority champions do all the work, which is often how collaborations devolve. Instead, the champions facilitate the discussions and check-in sessions, ensuring that participants know their roles and have a clear sense of the tasks necessary to move toward each benchmark. They check in on progress, asking that people honor their commitments or bring roadblocks to the full group to allow for mutual problem solving.

2. **Enlist People with Lived Experience:** Few things can motivate a group more than working side by side with families and young adults who have had to navigate the juvenile justice system. They bring an indispensable clarity about the urgency of the work, and their perspective will unleash ideas, strategies, and insights.

3. **Schedule Meetings and Find Meeting Locations Well in Advance:** Effective action teams jointly schedule regular meetings and set meeting locations well in advance. In this way, people know their deadlines for tasks. They also have the meetings on their calendars. Priority champions send reminders of upcoming meetings as well as tasks to be completed by that meeting.

4. **Chart Progress:** Every action team created a workplan, which included tasks and benchmarks at three-, six-, and twelve-month intervals. These plans may change and evolve, but it is essential that the teams have an updated version of the plan ready at

every meeting. All progress should be noted, and future benchmarks clearly identified. In this way, the community can chart progress, which builds momentum. It also facilitates learning, as the team can evaluate the factors that are contributing to plans being completed or not.

5. **Coordinate with All Teams:** Building on its strong track record in cross-sector collaboration, County leaders will realize success far more quickly and effectively by incorporating action team captains into existing formal and informal planning discussions. This allows the full community to engage with the work of all teams, which is essential as the leadership seeks to obtain funding, develop data sharing agreements, and respond to emerging priorities.

It is also helpful to recognize the leadership and efforts of community members who give their time, resources, and efforts to create system change in Lubbock County. Award ceremonies, recognition in the local press, and other creative ways to recognize people will build motivation and propel local leadership. The community might also consider orienting new elected officials to the work of the community, inviting them to be part of these efforts.

## PRIORITIZE IMPLEMENTATION OF CURRENT STATUTES

Many statutes are difficult to implement as they require coordination between multiple agencies, and the statutes do not designate the lead agency. Further, the laws require cross-sector planning and resource allocation. The formal and informal structures of cross-system collaboration in Lubbock County are ideal venues to assess the extent to which the systems of youth mental health and juvenile justice are aligned with current statutes.

As stated in the background section of this report, the Judicial Commission on Mental Health recently released the Third Edition of the Texas Juvenile Mental Health and Intellectual and Developmental Disabilities Law Bench Book, which provides community and juvenile justice stakeholders with a comprehensive overview of best practices and existing laws at each point at which children intersect or are at risk of intersecting with the juvenile justice system. For a comprehensive overview of the Texas juvenile justice system, statutes and case law, refer to Texas Juvenile Law, 9th Edition, by Professor Robert O. Dawson.

## REMAIN CURRENT WITH THE LATEST RESEARCH AND BEST PRACTICES

The field of youth justice is constantly evolving, with new research and promising innovations emerging constantly. Moreover, every time a county such as Lubbock brings together stakeholders from across systems to create systemic change for youth, these communities develop their own unique approaches to common problems. Remaining current on the latest research is key. Of equal importance is connecting with other communities across Texas who have also completed their own youth SIM mapping.

The Judicial Commission on Mental Health is your resource for continued technical assistance (TA). The TA site includes training and education, a video library, and peer networking resources. You can contact JCMH directly with questions and requests for assistance.

# APPENDICES

| APPENDIX | TITLE |
|---|---|
| Appendix 1 | Commonly Used Acronyms |
| Appendix 2 | General Resources |
| Appendix 3 | Lubbock Youth SIM Map |
| Appendix 4 | Workshop Participant List |
| Appendix 5 | Workshop Agenda |
| Appendix 6 | Best Practices at Each Intercept |
| Appendix 7 | Key References |

## APPENDIX 1| COMMONLY USED ACRONYMS

| | | |
|---|---|---|
| ACEs – Adverse Childhood Experiences | BJA – Bureau of Justice Assistance | CCP – Code of Criminal Procedure |
| CIRT – Crisis Intervention Response Team | CIT – Crisis Intervention Team | CSO –County Sheriff's Office |
| DAEP – Disciplinary Alternative Education Program | DAO –District Attorney's Office | HB – House Bill |
| HHSC – Health and Human Services Commission | IDD – Intellectual or Developmental Disability | IDEA – Individuals with Disabilities Education Act |
| IEP – Individualized Education Program | JCMH – Judicial Commission on Mental Health | JJAEP – Juvenile Justice Alternative Education Program |
| LE – Law Enforcement | LIDDA – Local IDD Authority | LMHA – Local Mental Health Authority |
| MH – Mental Health | MHC – Mental Health Court | MI – Mental Illness |
| MOU – Memorandum of Understanding | PD – Police Department | PDO – Public Defender's Office |
| PH – Public Health | RTC – Residential Treatment Center | SAMHSA – Substance Abuse & Mental Health Services Administration |
| SB – Senate Bill | SH – State Hospital | SRO – School Resource Officer |
| TASC – Texas Association of Specialty Courts | TCHATT – Texas Child Health Access Through Telemedicine | TCIC – Texas Crime Information Center |
| TCOOMMI – Texas Correctional Office on Offenders with Medical or Mental Impairments | TIDC – Texas Indigent Defense Commission | TJJD – Texas Juvenile Justice Department |
| TLETS – Texas Law Enforcement Telecommunications System | | Additional acronyms are described at the bottom of this page. |

## APPENDIX 2| GENERAL RESOURCES

### FUNDING RESOURCES

| | |
|---|---|
| Council of State Governments Justice Center<br>https://csgjusticecenter.org/projects/justice-and-mental-health-collaboration-program-jmhcp/funding-resources/ | DOJ Office of Justice Programs<br>https://www.ojp.gov/funding/explore/current-funding-opportunities |
| Humanities Texas<br>https://www.humanitiestexas.org/grants/apply | The Meadows Foundation<br>https://www.mfi.org/ |
| Office of the Texas Governor<br>https://gov.texas.gov/organization/financial-services/grants | Substance Abuse and Mental Health Services Administration<br>https://www.samhsa.gov/grants |
| Texas Health & Human Services Commission<br>https://www.hhs.texas.gov/business/grants | Texas Indigent Defense Commission<br>http://www.tidc.texas.gov/funding/ |
| U.S. Department of the Treasury: Assistance for State, Local, and Tribal Governments<br>https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and-tribal-governments | U.S. Grants<br>https://www.usgrants.org/texas/personal-grants |

### GRANT WRITING RESOURCES

| | |
|---|---|
| Grants.gov<br>https://www.grants.gov | HHSC Grant Information<br>https://www.hhs.texas.gov/business/grants |
| University of Texas Grants Resource Center<br>https://diversity.utexas.edu/tgrc/ | Nonprofit Ready<br>https://www.nonprofitready.org/grant-writing-classes |
| Texas Specialty Court Resource Center<br>https://www.txspecialtycourts.org/resources/grants.html | |

## MENTAL HEALTH COURT PROGRAM RESOURCES

Council of State Governments Justice Center – *Developing a Mental Health Court: An Interdisciplinary Curriculum*

https://www.arcourts.gov/sites/default/files/Mental%20Health%20Courts%20-%20Planning%20Guide.pdf

Council of State Governments Justice Center – *A Guide to Collecting Mental Health Court Outcome Data*

https://csgjusticecenter.org/wp-content/uploads/2020/01/MHC-Outcome-Data.pdf

Council of State Governments Justice Center – *A Guide to Mental Health Court Design and Implementation*

https://csgjusticecenter.org/wp-content/uploads/2020/01/Guide-MHC-Design.pdf

Council of State Governments Justice Center – *Mental Health Courts: A Guide to Research-Informed Policy and Practice*

https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_MHC_Research.pdf

Council of State Governments Justice Center – Mental Health Court Learning Modules

https://csgjusticecenter.org/projects/mental-health-courts/learning/learning-modules/

Judicial Commission on Mental Health: *10-Step Guide*

http://texasjcmh.gov/media/czaoapye/mhc-the-10-step-guide.pdf

Judicial Commission on Mental Health

http://texasjcmh.gov/technical-assistance/mental-health-courts/

Texas Association of Specialty Courts

http://www.tasctx.org/

Texas Specialty Court Resource Center

http://www.txspecialtycourts.org/

## TECHNICAL ASSISTANCE RESOURCES

Activities of the Service Members, Veterans, and Their Families Technical Assistance Center

https://www.samhsa.gov/smvf-ta-center/activities

Correctional Management Institute of Texas

http://www.cmitonline.org/technical-assistance.html

Doors to Wellbeing: National Consumer Technical Assistance Center

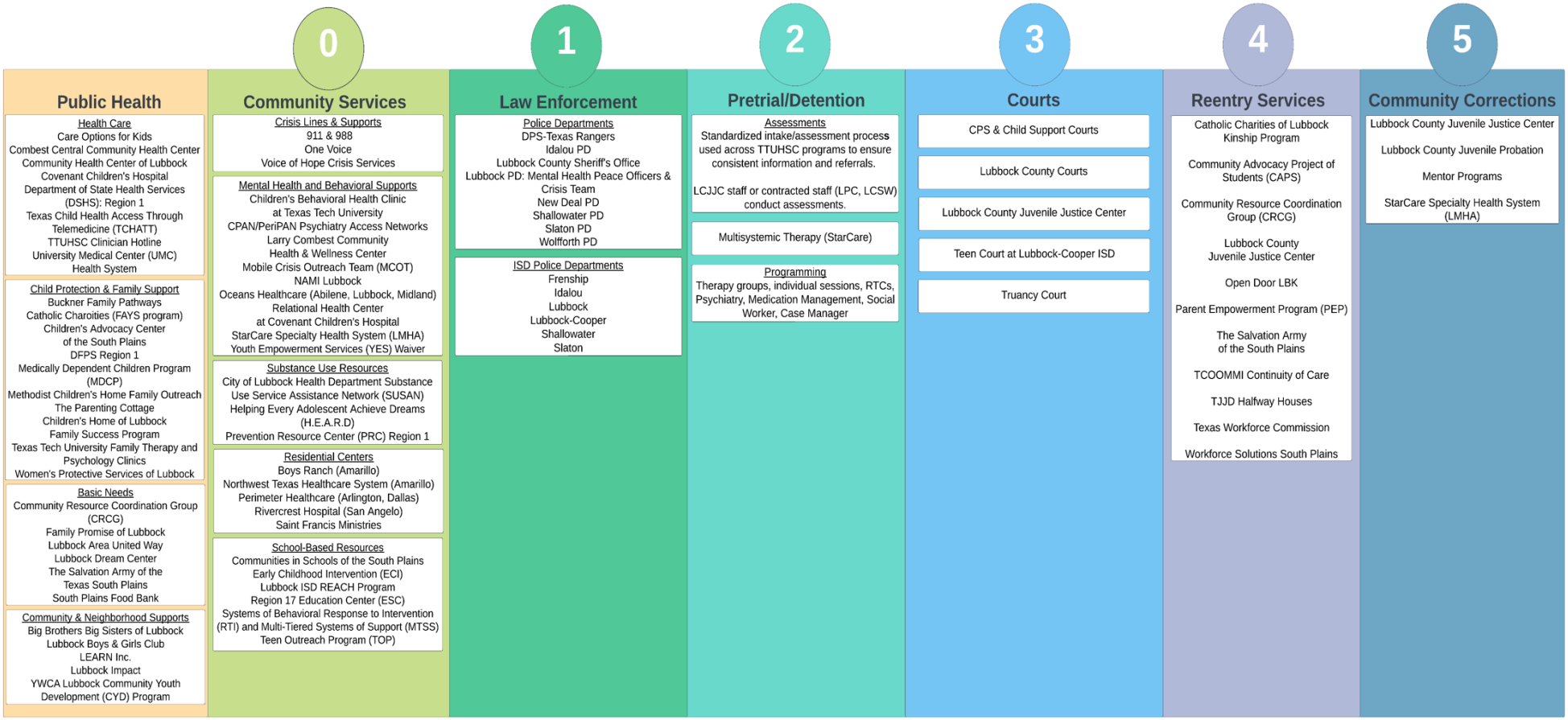
https://www.doorstowellbeing.org/

HHSC's Technical Assistance Center

https://txbhjustice.org/services/sequential-intercept-mapping

| | |
|---|---|
| Judicial Commission on Mental Health<br><br>http://texasjcmh.gov/technical-assistance/ | Justice Center: The Council of State Governments<br><br>https://csgjusticecenter.org/resources/justice-mh-partnerships-support-center/ |
| National Center for State Courts<br><br>https://www.ncsc.org/services-and-experts/areas-of-expertise/access-to-justice/tech-assistance | National Child Traumatic Stress Network<br><br>https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems/justice |
| National Family Support Technical Assistance Center<br><br>https://www.nfstac.org/request-ta | National Mental Health Consumers' Self-Help Clearinghouse<br><br>https://www.mhselfhelp.org/technical-assistance |
| National Training & Technical Assistance Center for Child, Youth, & Family Mental Health<br><br>https://nttacmentalhealth.org/trainings-ta/ | NPC Research<br><br>https://npcresearch.com/services-expertise/technical-assistance-and-consultation/ |
| Opioid Response Network<br><br>https://opioidresponsenetwork.org/ | Technical Assistance Collaborative<br><br>https://www.tacinc.org/what-we-do/customized-ta-training/ |
| Texas Specialty Court Resource Center<br><br>https://www.txspecialtycourts.org/resources/resource-request.html | |

## APPENDIX 3| LUBBOCK COUNTY YOUTH SIM MAP



## APPENDIX 4| PARTICIPANT LIST

| First Name | Last Name | Title/Role | Organization |
|---|---|---|---|
| Amanosi | Agbugui | Clinical Psychology Intern | TTUHSC |
| Marle | Antu | Chief of Behavioral Health Ops | StarCare Specialty Health System |
| Mahnoor | Azmat | PGY IV Resident | TTUHSC |
| Westley | Bailey-Gray | Clinical Social Worker | TTUHSC |
| Adam | Barrera | Campus Program Director | Texas Girls and Boys Ranch |
| Johanna | Belford | Director of Initiatives | CASA of the South Plains |
| Hannah | Bigbie | Community Impact Coordinator | Lubbock Area United Way |
| Marlise | Boyles | Assistant District Attorney | Lubbock County Criminal DA Office |
| Kristina | Brown | LMHA Director | StarCare Specialty Health System |
| Bonnie | Cantu | Sr. Prog. Dir. - Student Clin. Serv. | TCHATT Dept. of Psychiatry TTUHSC |
| Jeff | Carr | Managing Director | TTUHSC |
| Bobby | Carter | Director of Diversion Programs | StarCare |
| Patti | Castro | Director of Advocacy | CASA of the South Plains |
| Kendra | Cates | BH Partnership Program Liaison | StarCare |
| Augusta | Cushman | Family Partner | StarCare |
| Lucas | Divine | ED Strategy & Planning | Covenant Health System |
| Martha | Dodge | Dir. of Student Behavioral Support | Lubbock ISD |
| Jade | Dominguez | Chief Program Officer | CASA of the South Plains |
| Mary | Duenes | Care Coordinator | Voice of Hope |
| Brian | Ellyson | Dir. Student & Parent Resolutions | Lubbock ISD |
| Rene | Esparza | Dir. Placement, Transp. & CU | Saint Francis Ministries |
| Cynthia | Fry | Director of Mental Health | Lubbock County Juvenile Justice Center |
| Cristian | Garcia | President of Texas | Saint Francis Ministries |
| Lacey | Gordon | LIDDA Director | StarCare Specialty Health System |
| Kelly | Grace | Crisis Intervention Counselor | Frenship ISD |
| Bailey | Hagler | Comm.-Based Mental Health Dir. | StarCare |
| Sandra | Hanson | Clinical Utilization & CANS Sup. | Saint Francis Ministries |
| Samanthia | Harrison | CAP Postdoctoral Fellow | TTUHSC |

| | | | |
|---|---|---|---|
| Tavia | Hatfield | Executive Director | Covenant |
| Mistie | Hill | Rainbow Room Coordinator | DFPS/ FBCE |
| Sarah | Hostick | Crisis Intervention Counselor | Frenship ISD |
| Caeden | Jenkins | Community Liaison | Oceans Healthcare |
| Connie | Jimenez | Regional Manager | Maximus/Texas STAR Medicaid Managed Care Prog./Texas Health Steps Outreach |
| Lara | Johnson | Chief Medical Officer | Covenant Health |
| Kodi | Keeling | Clinical Utilization Specialist | Saint Francis Ministries |
| Kristy | Keeling | Clinical Utilization Specialist | Saint Francis Ministries |
| Esmeralda | Kennedy | ED of Support Services | Saint Francis |
| Stephanie | Kopanski | FY1 Child & Adol. Psychiatry | TTUHSC |
| Kristen | Lewis | Education Specialist | ESC 17 |
| Libby | Linker | Community Impact Director | Lubbock Area United Way |
| Melanie | MacKenzie | Executive Director | Saint Francis Ministries |
| Sabrina | Marcum | Children's MH System Navigator | StarCare |
| Ayda | Martinez | Director | SPAG 211/ADRC |
| Mercedes | Martinez | Substance Use Coordinator | Lubbock Public Health |
| Vicente | Martinez | Trauma/Injury Prevention Outreach Coordinator | Covenant Health System |
| Lauryn | McElmurry | Manager of Care Management | Covenant Health Partners |
| Melissa | McNamara | Lubbock Co. Crim. Assoc. Judge | Lubbock County |
| Ray | Mendoza | Chief of Police | Frenship ISD Police |
| Melissa | Moreno | Nurse Manager | Covenant Children's Hospital |
| Ethan | Noble | Crisis Intervention Team | Lubbock Police Department |
| Andrea | Parker | Network Management Div. Dir. | StarCare Specialty Health System |
| Brian | Payne | CMO UMC Children's Hospital | UMC Health System |
| Kayla | Perfetto | Clinical Psychology Intern | TTUHSC |
| Tammi | Pillow | Program Director | Texas Girls & Boys Ranch |
| Frances | Quintero | Community Liaison | Texas Tech Mental Health Initiative |
| Mike | Ragain | CMO | UMC |

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|---|---|---|---|
| Melanie | Rosa | Assistant to Chief Program Officer | Saint Francis Ministries |
| Ujala | Sehar | Senior Research Assistant | TTUHSC |
| Arsalan | Shah | Physicians trainee | TTUHSC |
| Brian | Shannon | Horn Professor | Texas Tech School of Law |
| Gulnaz | Siddiqui | Resident Physician | Covenant Children's |
| Ginny | Simpson | Juvenile Division Chief - Asst. DA | Lubbock County Criminal DA Office |
| Scott | Sims | ED of Administrative Services | Frenship ISD |
| Amy | Smallwood | Ed. Specialist in MH/Crisis | Region 17 ESC |
| Dennis | Smith | Juvenile Probation Supervisor | Lubbock County Juvenile Justice Center |
| Marshall | Smith | C&A Programs Director | StarCare Specialty Health System |
| Craig | Thomson | Director of Counseling | Frenship ISD |
| Sydney | Tipton | Market Development Director | Oceans Healthcare |
| Jana | Townsend | Social Worker | Covenant Health Outreach |
| Nancy | Trevino | Director - TTMHI | TTUHSC |
| Hunter | Turnipseed | Regional Alignment Coordinator | Lubbock Public Health |
| Amada | Vieregge | YES Waiver Team Lead | StarCare Specialty Health System |
| Alexis | Villarreal | Policy Fellow | MHA of Greater Houston |
| Teresa | Vitela | Local Authority Division Director | StarCare Specialty Health System |
| Sarah | Wakefield | Chair, Professor | TTUHSC |
| Stephen | Warren | President | Community Foundation of West Texas |
| Aubrey | Williams | CAP Postdoctoral Fellow | TTUHSC |
| Rachel | Williams-Ehue | Vice President of Permanency | Saint Francis Ministries |
| John | Wuerflein | Student Behavior Coach | Frenship ISD |
| Amanda | Yaeger | CCBHC Director | StarCare |
| Kaela | Yamini | Predoctoral Intern | TTUHSC |
| Kathy | Young | Clinical Utilization Specialist | Saint Francis Ministries |
| Sardar | Zahid | Program Manager | TTUHSC |
| Diana | Zubia Rae | Trafficking Survivor & Corr. Adv. | Voice of Hope |

## APPENDIX 5| WORKSHOP AGENDA

### Youth Sequential Intercept Model Mapping Workshop

**Lubbock County**
**Tuesday, October 14, 2025**
**YWCA of Lubbock, 6501 University Avenue**

Purpose and Goals:

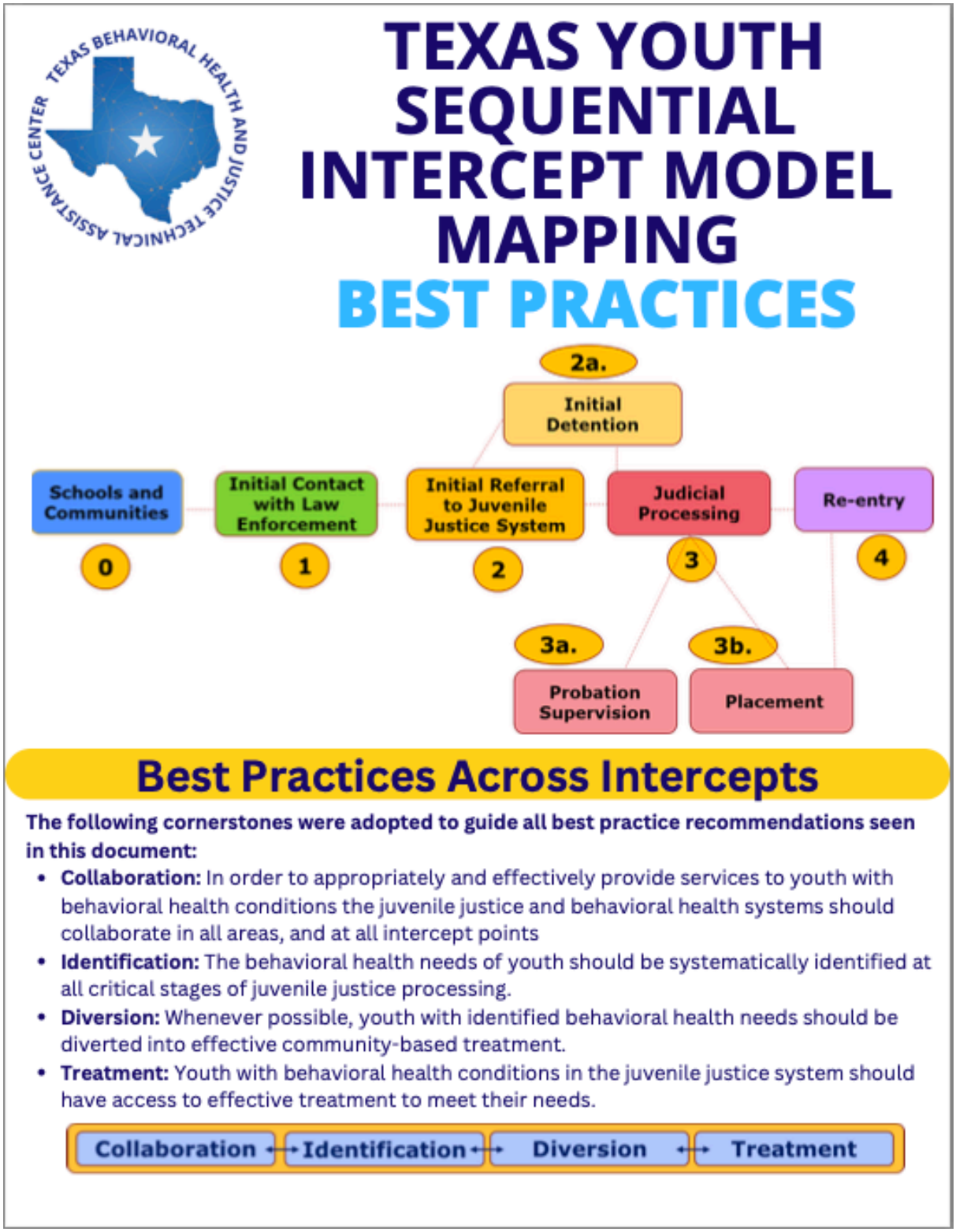
- Facilitate mutual understanding, collaboration and relationship building between a diverse array of stakeholders, all of whom are dedicated to system transformation
- Identify best practices, resources, gaps in services, and opportunities for improvement and innovation across all SIM intercepts
- Prioritize key steps toward system transformation and improved service delivery and identify relevant best practices
- Create a longer term strategic action plan with measurable outcomes, optimizing use of local resources and furthering the delivery of appropriate services

**AGENDA**

| | | |
|---|---|---|
| **8:30 am** | **Registration & Networking** | |
| **9:00 am** | **Opening Remarks** | Welcome & Community Goals |
| **9:20 am** | **Orienting to This Work**<br>Lynda Frost | Hopes for the Mapping Process<br>Why Collaboration Matters |
| **9:40 am** | **Overview of Judicial Commission**<br>Andy Perkins | |
| **9:45 am** | **Overview of SIM Mapping**<br>Doug Smith | Overview of Model<br>Importance of Lived Experience |
| **10:30 am** | **Break** | |
| **10:45 am** | **Establishing Priorities**<br>Lynda Frost | Identify Possible Priorities<br>Identify Opportunities for Collaboration |
| **11:45 am** | **Lunch** | |
| **12:20 pm** | **Action Planning**<br>Doug Smith | Group Work<br>Presentation to Full Group |
| **1:40 pm** | **Break** | |

| | | |
|---|---|---|
| **1:55 pm** | **Refining the Action Plan**<br>Doug Smith | Gallery Walk<br>Group Work |
| **2:35 pm** | **Next Steps & Summary**<br>Lynda Frost | Meeting to Review Draft Report<br>3-month Progress Check-In<br>Individual Next Steps |
| **3:00 pm** | **Adjourn** | |

## APPENDIX 6| BEST PRACTICES AT EACH INTERCEPT



# INTERCEPT 0: SCHOOLS AND COMMUNITY BASED SERVICES BEST PRACTICES

## EARLY IDENTIFICATION AND PREVENTION

- ◯ Universal school-based needs and risk assessments
- ◯ Mental health screenings by primary care providers
- ◯ Information sharing agreements across behavioral health and justice stakeholders
- ◯ Regular meetings/staffings of Community Resource Coordination Groups and Children's Advocacy Centers

## SCHOOL-BASED DIVERSION AND BEHAVIORAL HEALTH SUPPORTS

- ◯ Multi-tiered Systems of Support (MTSS)
- ◯ Onsite school mental health providers, case management, wraparound services and family engagement specialists
- ◯ Treatment referral pathways (i.e. Texas Child Health Access Through Telemedicine, ,TCHATT, and Child Psychiatric Access Network (CPAN)
- ◯ Alternatives to exclusionary discipline
- ◯ Regular evaluation of school discipline policies (i.e. review code of conduct)
- ◯ Juvenile Justice Alternative Education Programs (JJAEP)/ Disciplinary Alternative Education Program (DAEP) transition planning and continuity of care

## SOMEONE TO CALL

- ◯ Crisis hotlines (988 Suicide and Crisis Lifeline)
- ◯ Child and family helplines
- ◯ Mentorship programs

## SOMEONE TO RESPOND

- ◯ Youth Mobile Crisis Outreach Teams (Youth Crisis Outreach Teams, or Mobile Response and Stabilization Services)
- ◯ Certified Family Partners
- ◯ Wraparound case management (i.e. YES Waiver)

## A PLACE TO GO

- ◯ Children's Crisis Respite Units
- ◯ Trauma-informed Residential Treatment Centers (RTCs)
- ◯ Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs for children (PHPs)
- ◯ Youth Assessment Centers
- ◯ Substance use disorder treatment centers (detox, inpatient, outpatient)

# INTERCEPT 0: BEST PRACTICE HIGHLIGHTS

| Best Practice | Description |
|---|---|
| **Early Identification and Prevention** | |
| **Universal school-based risk and needs assessments** | Use validated screening tools used for youth flagged with behavioral needs. See Mental Health Screening Tools for Grades K-12 |
| **Mental health screenings by primary care providers** | Standardize the use of depression and anxiety screening for youth ages 8-18 during pediatric wellness visits. See Pediatric Symptom Checklist-17 or the Strengths and Difficulties questionnaire |
| **Information sharing agreements** | Establish Memorandums of Understanding (MOUs) between school mental health professionals and the LMHA/LBHAs to support continuity of care for youth with identified behavioral health needs. |
| **School-based Diversion and Behavioral Health Supports** | |
| **Multi-Tiered Systems of Support (MTSS)** | MTSS is a comprehensive **three-tiered** system of support to provide both universal and tailored mental health support to school-aged youth.<br>• Universal mental health promotion and training<br>• Targeted mental health intervention<br>• Intensive mental health intervention |
| **Alternatives to Exclusionary Discipline** | Regularly review district discipline policies and consider the use of restorative justice practices, diversion programing and family support to reduce expulsions. Remove code of conduct language reflecting zero tolerance policies. See the School Crime and Discipline Handbook for guidance. |
| **Onsite school behavioral health providers** | Establish partnerships between LMHAs/LBHAs and school-based mental health providers to provide a system of support to youth and their families. |
| **Crisis Continuum: Someone to Call, Someone to Respond, a Place to Go** | |
| **Crisis Hotlines** | 24/7 call, text and chat lines for people experiencing a behavioral health crisis. Operators provide screening, intervention and referrals to community resources. |
| **Crisis Outreach Teams** | Qualified mental health professionals proving community-based crisis assessment, intervention and continuity of care. Youth MCOT providers coordinate with schools, law enforcement, hospitals and detention facilities to provide care. |
| **Children's Crisis Respite Units** | Short-term residential crisis services for youth with low risk of harm to self or others. Provide 24-hour observation in a home-like environment to provide youth a "break" from existing environmental stressors. |

# INTERCEPT 1: LAW ENFORCEMENT & EMERGENCY HEALTH SERVICES BEST PRACTICES

## LAW ENFORCEMENT MENTAL HEALTH TRAINING

- Mental Health Deputies with specialized youth training
- Crisis Intervention Team Training: CIT for Youth
- Youth Mental Health First Aid (MHFA) training for law enforcement
- Behavioral health specific trainings on adolescent brain development, trauma informed practices, crisis intervention and de-escalation and adverse childhood experiences

## POLICE DIVERSION PROGRAMS

- Regular referral to behavioral health treatment and providers
- Warning notices for youth engaging in disruptive behaviors
- Informal law enforcement dispositions without referral to juvenile court (internal conditions set)
- First Offender Programs (Tex. Fam. Code Sec. 52.031)
- Collaboration with parents and guardians to select conditions of release

## LAW ENFORCEMENT AND MENTAL HEALTH PROVIDER COLLABORATION

- Law enforcement behavioral health co-responder teams
- Resource sharing between behavioral health providers and law enforcement
- Dispatch and police coding of calls involving children experiencing a mental health related crisis
- Role clarification and protocol evaluation on school-based law enforcement response to disruptive behaviors
- Data and information sharing between law enforcement, school districts and behavioral health providers (e.g. MOUs)

# INTERCEPT 1: BEST PRACTICE HIGHLIGHTS

| Best Practice | Description |
|---|---|
| **Law Enforcement Mental Health Training** | |
| **Crisis Intervention Team Training: CIT for Youth** | CIT for Youth provides training to law enforcement officers to help prevent mental health crises and to help de-escalate crises when they occur.<br><br>Involves collaboration between law enforcement, families and youth, schools, community mental health providers and child-serving agencies committed to ensuring that youth in a mental health crisis are identified and referred to appropriate mental health services. |
| **Tailored behavioral health trainings for law enforcement** | **Youth MHFA:** Teaches guardians, teachers, school administrators, peers, law enforcement, community behavioral health providers, and juvenile justice stakeholders how to identify and respond to an adolescent who is experiencing a behavioral health crisis.<br><br>**Trust Based Relational Therapy:** An attachment-based, trauma-informed intervention that is designed to meet the complex needs of vulnerable children.<br><br>For additional specialized behavioral health trainings on adolescent brain development, Adverse Childhood Experiences, and de-escalation strategies explore the Neurosequential Model of Therapeutics. |
| **Police Diversion Programs** | |
| **Regular referral to behavioral health treatment and providers** | Law enforcement departments can establish a referral process after or during crisis episodes to coordinate care with behavioral health providers who otherwise may not be aware of mental health related emergency incidents. |
| **First Offender Programs** | Involves voluntary rehabilitation services designated by a law enforcement agency or the juvenile board prior to the filing of a criminal charge against a child accused of conduct indicating a need for supervision or a Class C misdemeanor. (Tex. Fam. Code Sec. 52.031) |
| **Law Enforcement and Mental Health Provider Collaboration** | |
| **Co-responder Teams** | Paired teams of specially trained officers and mental health clinicians that respond to mental health calls for service. Trained in specialized youth interventions. |
| **Role clarification and protocol evaluation on school-based law enforcement response** | Involves school resource officers or school-based law enforcement establishing protocol that guide decisions related to behavioral interventions in the classroom. School administrators, teachers and school behavioral health staff should all be educated on appropriate use of law enforcement intervention in schools and explore alternatives to law enforcement response when appropriate. |

# INTERCEPT 2: INITIAL REFERRAL AND INITIAL DETENTION BEST PRACTICES

## JUVENILE PROBATION BEHAVIORAL HEALTH ASSESSMENT, TREATMENT, AND INTERVENTION

- ◯ Validated risk and needs assessment tools to make treatment recommendations and referrals
- ◯ Detention-based behavioral health providers (consider telehealth options)
- ◯ Detention liaisons and case managers
- ◯ High quality correctional education
- ◯ Evidence-based treatment in detention (e.g., Multi-systemic Therapy, Dialectical Behavioral Therapy, Neurosequential Model of Therapeutics)
- ◯ Trauma informed trainings for all detention and juvenile probation staff
- ◯ Regular review of detention discipline policies

## COURT DIVERSION AND PREVENTION PROGRAMS

- ◯ Administrative conditions of release at intake (Tex. Fam. Code Sec. 53.02)
- ◯ Use risk-needs assessments to inform court recommendations
- ◯ Reduced juvenile justice system involvement for youth with low risk to re-offend
- ◯ Appointed counsel when there is any question about the parent or guardian's ability to retain counsel
- ◯ Specialized conditions of release to connect youth to treatment
- ◯ Fines replaced with pro-social activities (community service, mentoring programs etc.)

## JUVENILE JUSTICE STAKEHOLDER COLLABORATION

- ◯ Regular juvenile justice meetings between juvenile probation, detention, LMHA/LBHA, courts and the child's guardian
- ◯ Coordinated case planning between child protection and juvenile justice staff for youth who are involved in both systems
- ◯ Tracking juvenile justice referral data
- ◯ Behavioral Health Services Online (BHSO) to identify youth with prior public mental health systems involvement
- ◯ MOUs and ROIs between juvenile court and LMHA/LBHAs to share relevant behavioral health assessment data

# INTERCEPT 2: BEST PRACTICE HIGHLIGHTS

| Best Practice | Description |
|---|---|
| **Juvenile Probation Behavioral Health Assessment, Treatment, and Intervention** | |
| **Validated risk and needs assessments** | Validated risk and needs assessments provide an opportunity to assess the primary cause of the youth's delinquent behavior (dynamic risk factors) and focus interventions on these factors. Dynamic factors are those that can be changed as part of the normal developmental process or through system interventions.<br><br>Use the PACT and MAYSI to inform treatment referrals and conditions of release. |
| **Regular review of detention discipline policies** | Adopt policies that require administrative review of all restraints and seclusions. Consider alternatives (when appropriate) to administrative seclusions using trauma-informed approaches to care.<br>• See SAMHSAs recommendations |
| **Detention-based behavioral health providers** | Clinicians positioned within detention facilities and juvenile probation departments can attend to ongoing crisis mental health needs and offer SUD treatment, brief therapy interventions and case management to detained youth. |
| **Court Diversion and Prevention Programs** | |
| **Specialized conditions of release** | Opportunity for judges to connect youth with behavioral health needs to evidence-based treatment and prosocial activities such as community service or mentoring programs.<br>Conditions should be informed by what services are available in the community to support youth with behavioral health needs and the capacity of the youth and their guardian to comply with the conditions. |
| **Juvenile Justice Stakeholder Collaboration** | |
| **Coordinated Case Planning** | Ongoing collaboration between child welfare and juvenile justice staff to communicate content of their respective case plans, identify gaps and redundancies and become aware of requirements with which youth and their families must contend. See Child Welfare and Juvenile Justice System Involvement snapshot. |
| **Use Behavioral Health Services Online (BHSO)** | Local probation departments can use BHSO to identify youth who have had contact within the last 3 years (probable or exact matches) with the public mental health system to coordinate care and ensure there is continuity in service provision. |
| **Track juvenile referral data** | Explore relevant trends in outcomes data including, number of juvenile probation referrals, number of positive youth screenings for Serious Emotional Disturbance (SED) or SUD, number of connections to treatment, and rates of recidivism. |

# INTERCEPT 3: JUDICIAL PROCESSING, PROBATION SUPERVISION AND PLACEMENT BEST PRACTICES

## SPECIALIZED COURT INTERVENTIONS

- Specialty juvenile treatment courts
- Specialty court caseloads in rural counties
- Juvenile court case managers and liaisons
- Developmentally appropriate assessment tools to create individualized treatment plans
- Juvenile court personnel training in trauma informed approaches to care and decision making

## PRE-TRIAL INTERVENTIONS

- Pre-trial supervision and diversion programs:
  - Supervisory Caution
  - Deferred Prosecution Program
  - Referral to Community Resource Coordination Group (CRCG)
- Family engagement: provide education, involve in treatment planning, and assist in accessing social supports

## STREAMLINED FITNESS RESTORATION PROCESSES

- Continuity of care for youth found unfit to proceed
- Regular meetings between court and juvenile justice stakeholders to review the status of fitness restoration cases in the county
- Outpatient fitness restoration as an alterative to inpatient fitness restoration
- Regular trainings and education to courts on Chapter 55 (see Texas Juvenile Mental Health and Intellectual and Developmental Disabilities Law Bench Book)

# INTERCEPT 3: BEST PRACTICE HIGHLIGHTS

| Best Practice | Description |
|---|---|
| **Specialized Court Interventions** | |
| Specialty Juvenile Treatment Courts | Provide opportunities to keep youth in the community, provide connection to community-based services and reduce recidivism by treating the behavior (e.g. mental health courts and juvenile drug courts).<br><br>See resources on how to start a mental health court here. |
| Juvenile Court Case Managers/ Liaisons | Role established to coordinate care in the community for youth identified with ongoing behavioral health needs between school, courts, community providers and county detention facilities.<br><br>Juvenile case managers can be employed by justice and municipal courts to support early identification of behavioral health needs and inform both judges and prosecutors of a youth's treatment needs. |
| **Pre-trial Interventions** | |
| Pre-Trial Supervision and Diversion Programs | Voluntary opportunities for juvenile probation departments and courts to offer pre-adjudication diversion programs to youth in order to access treatment in the least restrictive setting.<br>• *Supervisory Caution (also known as counsel and release)* - Can include referrals to a social services agency or a community-based first offender program, contacting parents to inform them of the youth's activities, or warning the youth about the activities in the accusation.<br>• *Deferred Prosecution*- Alternative to formal adjudication for delinquent conduct or Conduct Indicating a Needs for Supervision (CINS). Can be offered by a probation officer, a prosecutor or a judge. (Tex. Fam. Code Sec. 53.03)<br>• *Referral to CRCG*- Diversion option for youth under 12 years of age. The CRCG develops a community referral and service plan that offers recommendations to the probation department who then can monitor compliance with the plan for up to three months. (Tex. Family Code Sec. 53.01 (b-1)) |
| **Streamline Fitness to Proceed Processes** | |
| Continuity of care for youth found unfit to proceed | • Establish one point of contact between the county and state hospital (or private inpatient facility) that the youth is receiving restoration services.<br>• Ensure the case moves froward while the juvenile is hospitalized to ensure speedy resolution upon return (i.e. address discovery issues, and plea offers).<br>• Coordinate transportation within three days of notice that a juvenile has been restored.<br>• Establish quick court hearing setting policy upon return from state hospital to avoid decompensation. |

# INTERCEPT 4: RE-ENTRY BEST PRACTICES

## TRANSITION PLANNING

- ◯ Detention-based care coordinators or mental health liaisons
- ◯ Formalized family engagement processes (e.g. family genograms, family team meetings, family youth policy committees and engagement specialists)
- ◯ Regular behavioral health, education and juvenile justice stakeholder case staffing (explore existing Child Advocacy Center or Community Resource Coordination Group infrastructures)
- ◯ Pre-release intakes with LMHA/LBHAs

## TRAUMA-INFORMED SUPERVISION PRACTICES

- ◯ Graduated response matrix to guide supervision officer's response to technical violations of supervision
- ◯ Tailored mental health training for juvenile probation officers
- ◯ Specialized mental health and substance use caseloads
- ◯ Supervision plans guided by risk and needs assessments
- ◯ Regular trend analysis on supervision practices and outcomes

## COORDINATED AFTER-CARE SERVICES

- ◯ School-reenrollment after confinement process
- ◯ Access for youth and families to wraparound behavioral health resources (see intercept 0)
- ◯ Use of peers and family partners to support youth and families through transition
- ◯ Youth referrals to mentoring programs
- ◯ Supportive parental skill development

# INTERCEPT 4: BEST PRACTICE HIGHLIGHTS

| Best Practice | Description |
|---|---|
| **Transition Planning** | |
| **Formalized Family Engagement** | Create processes and protocols to support the involvement of guardians in key decision making throughout a youth's juvenile justice system involvement (from intake through reentry). Some examples include:<br>• *Family identification training*- Probation staff receive training on how to identify and engage with a youth's caregiver network.<br>• *Family genograms/ecomaps*- Visual tool to help facilitate conversations about existing social and system supports with youth and their family.<br>• *Family/youth policy committees*- Opportunity for juvenile justice systems to incorporate youth and families' voices by creating advisory boards, conducting regular surveys and administering interviews for youth exiting facilities or community programs. |
| **Pre-release intakes with LMHA/LBHA** | Juvenile probation departments can establish MOUs with LMHA/LBHAs to conduct intake assessments with youth identified as having an ongoing behavioral health need (in detention, post adjudication treatment facilities or TJJD facilities) prior to release. This provides an opportunity for a youth to be authorized into treatment with a LMHA/LBHA and improves continuity of care by reducing wait times for youth to be connected to services in the community. (See Texas Admin. Code Rule 301.353) |
| **Coordianted After-Care Services** | |
| **School-reenrollment after confinement processes** | Facilitate timely reenrollment in school for youth exiting juvenile justice facilities by removing barriers related to the transfer of educational records between locations, barriers to records sharing, and credit transfer policies that are not always compatible between districts.<br><br>Reenrollment can best be facilitated by liaisons or transition coordinators that facilitate the transfer of credits and school records and navigate the logistics involved in the transition process by acting as a point of contact for youth and their families. |
| **Trauma-Informed Supervision Practices** | |
| **Graduated Response Matrix** | Tool used to support objective decision making through standardized guidelines on responses to youth behavior and technical violations of probation. Employs a continuum of interventions to address youth misbehavior, as warranted by youth's assessed risk level and the nature of their non-compliance. See example matrix on page 39 of Core Principles for Reducing Recidivism and Improving Other Outcomes for Youth in the Juvenile Justice System. |
| **Supervision plans guided by risk and needs assessments** | The Risk-Needs Responsivity Model suggests that supervision plans should assess a youth's likelihood to reoffend, identify the dynamic risk factors that may need to be addressed and tailor intervention to the youth's learning style, motivation and strengths. |

## APPENDIX 7| KEY REFERENCES


| | |
|---|---|
| 1 | JUDICIAL COMMISSION ON MENTAL HEALTH, *TEXAS JUVENILE MENTAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITIES LAW BENCH BOOK* (3d Ed. 2023-2025), https://texasjcmh.gov/media/secdby2j/jbb-2023-corrected-formatting-with-links-4-26-24.pdf |
| 2 | THE JUSTICE CENTER, COUNCIL OF STATE GOVERNMENTS, HOW TO USE AN INTEGRATED APPROACH TO ADDRESS MENTAL HEALTH NEEDS OF YOUTH IN THE JUSTICE SYSTEM (2022), https://csgjusticecenter.org/publications/how-to-use-an-integrated-approach-to-address-the-mental-health-needs-of-youth-in-the-justice-system-2/?mc_cid=473739da81&mc_eid=eadd5775fa |
| 3 | NATIONAL CENTER FOR STATE COURTS, *JUVENILE JUSTICE MENTAL HEALTH DIVERSION GUIDELINES AND PRINCIPLES*, (2022), https://www.ncsc.org/__data/assets/pdf_file/0029/74495/Juvenile-Justice-Mental-Health-Diversion-Final.pdf |
| 4 | NATIONAL CENTER FOR STATE COURTS, FAIR JUSTICE FOR PERSONS WITH MENTAL ILLNESS: IMPROVING THE COURT'S RESPONSE 19 (2018), https://www.neomed.edu/wp-content/uploads/CJCCOE_10-Dave-Byers-COURT-RESOURCES-Mental-Health-Protocols-Oct-2018.pdf. *See also*, https://www.ncsc.org/behavioralhealth. |
| 5 | POLICY RESEARCH ASSOCIATES, THE SEQUENTIAL INTERCEPT MODEL: NEXT STEPS (HOW TO MAXIMIZE YOUR SIM MAPPING WORKSHOP), https://express.adobe.com/page/dSrgsE34zIea9/. *See also*, https://www.prainc.com/im/. |
| 6 | SAMHSA GAINS CENTER, DEVELOPING A COMPREHENSIVE PLAN FOR BEHAVIORAL HEALTH AND CRIMINAL JUSTICE COLLABORATION: THE SEQUENTIAL INTERCEPT MODEL (3rd ed., 2013); Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCH. SERVICES 544, 544-49 (2006), https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.4.544. The Youth Sequential Intercept Model in this report adopts the traditional model but also expands it to include new intercepts that allow for a better understanding of early intervention to effectively address those with mental health issues before they enter the criminal justice system. |
| 7 | PURVIS, KARYN B., ET AL, TRUST-BASED RELATIONAL INTERVENTION (TBRI): A SYSTEMIC APPROACH TO COMPLEX DEVELOPMENTAL TRAUMA, December 2013, Child Youth Serv. 34(4): 360-386. Https://pmc.ncbi.nlm.nih.gov/articles/PMC3877861/ |