October 2026

Improving mental health access for low-income, court-involved youth in rural counties

Prepared by Deborah Fabiyi, Washington State University and Project LINK staff

Mental health disorders are highly prevalent among youth involved in the juvenile justice system.

One systematic review of 47 studies[1] found:

- **About 1 in 4 girls** in juvenile detention and correctional facilities had major depression (26%), compared with about 11% of girls in the general population.
- **About 1 in 10 boys** in juvenile detention and correctional facilities had major depression (10%), compared with about 5% of boys in the general population.



Despite their higher need for mental health care, these youth face significant barriers to accessing care. Research suggests that only about 33% of detained or incarcerated youth use mental health services.[2]

Getting care is also especially hard for **rural and low-income families**. More than 60% of rural Americans live in designated mental health provider shortage areas.[3] Among children living in poverty who need mental health care, fewer than 15% receive services, and even fewer complete treatment.[4,5]

This brief examines strategies for improving access to mental health services for youth in Whitman County, Washington who face the overlapping challenges of low income, court involvement, and rural residence.

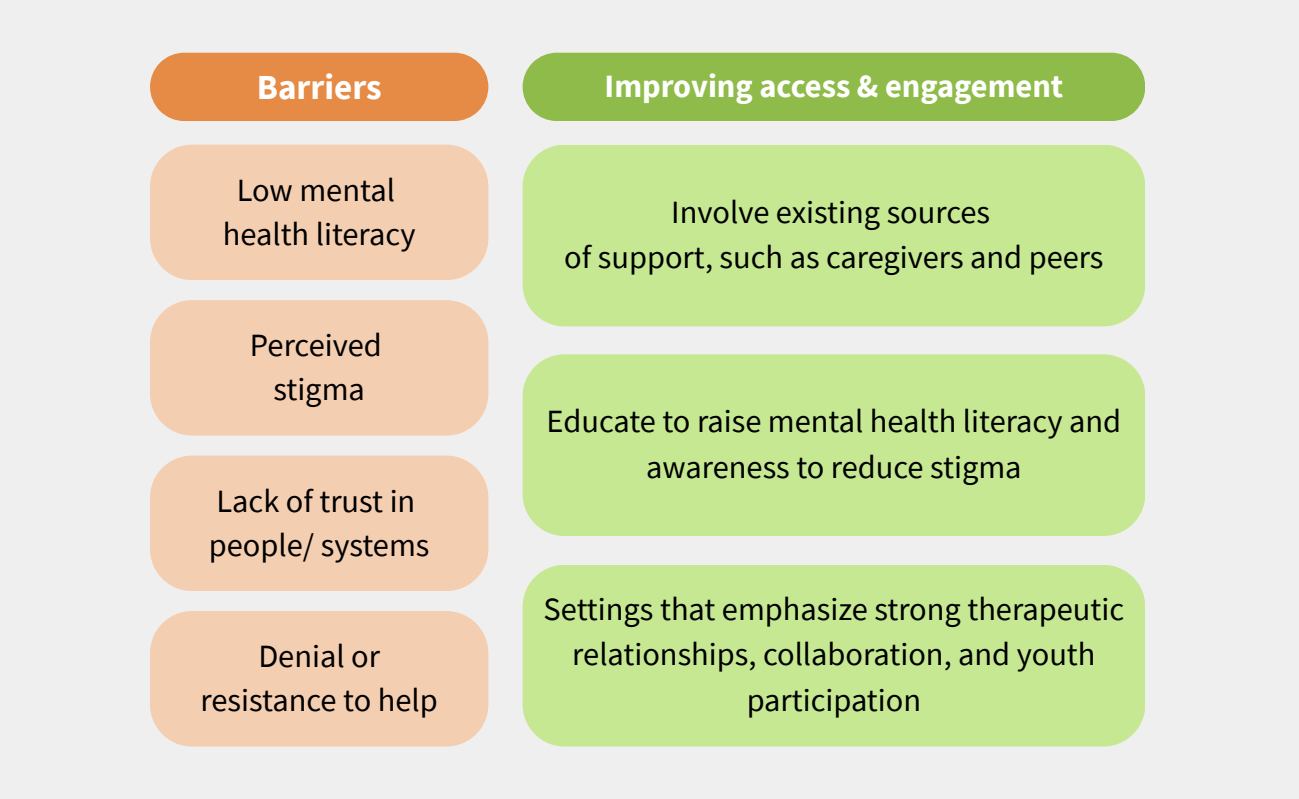


What the Research Says

Although we found no research that examines all three characteristics together (low income, court involvement, and rural residence), we reviewed syntheses that address each group separately and looked for the barriers and strategies that appear across them.

Youth involved in the justice system

A systematic review of qualitative studies[6] on justice-involved young people found four common barriers to mental health care, along with three ways to improve access and engagement:



A literature review of service systems for justice-involved youth with mental health needs found that services are often **fragmented and poorly coordinated** across justice, mental health, school, and child welfare systems.[7] Barriers after release included:

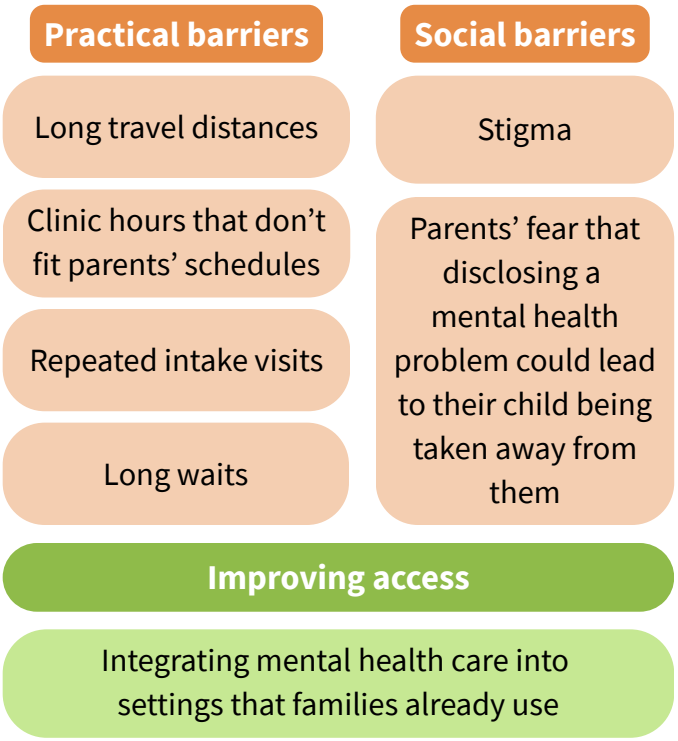
- Insufficient health coverage
- Difficulty navigating multiple systems
- Lack of local providers
- Transportation problems (in rural areas)

The review highlighted several promising approaches to overcome barriers, described under the Strategies section below.

Low-income youth and families

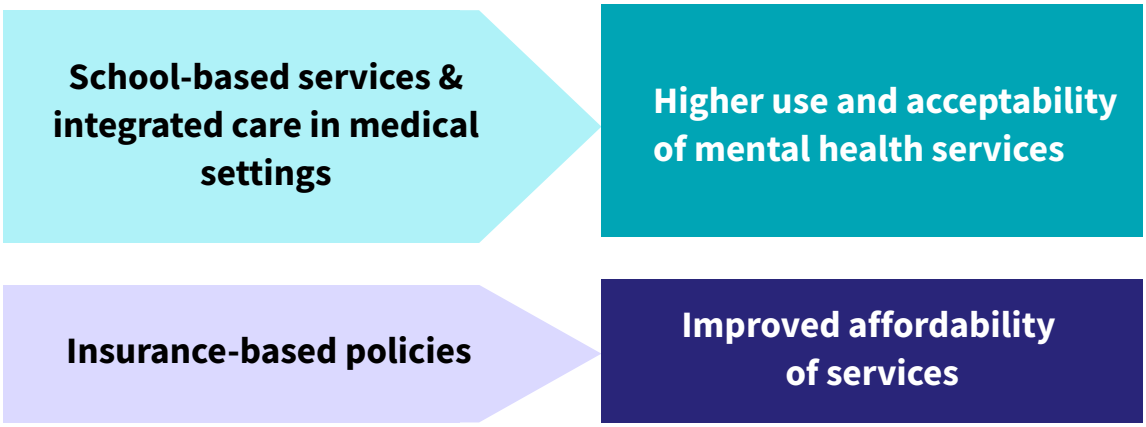
A report on improving access to mental health services for children in poverty identified practical and social barriers that often overlap with those experienced by rural families.[8]

The authors concluded that **integrating mental health care into settings that families already use**, such as their child's doctor's office, is the most promising way to improve access to care for low-income families.



A systematic review of 20 studies of children's mental health policies[9] found that:

- **School-based services** and **integrated care in medical settings** were associated with higher use and acceptability of services.
- **Insurance-based policies** showed some evidence for improving service affordability.
- The review did not identify any studies investigating **telehealth or workforce development policies**, highlighting important gaps in the evidence base.



Rural youth and families

A 2025 scoping review of U.S. studies of rural adolescents and parents[10] grouped the barriers they reported into four types:

Service accessibility	Whether services are available and reachable at all
Stigma and negaitve beliefs	Concerns about how seeking help will be seen and doubts about whether it helps
Service quality	Whether the care received meets youth and family needs
Social barriers	Barriers rooted in family, peer, and community circumstances

The authors recommended providing support outside traditional mental health settings, expanding technology-based services, expanding prevention, ensuring services exist for specific mental health concerns, offering culturally responsive and patient-centered care, increasing mental health literacy and addressing stigma, and addressing social conditions that affect service use.

Key Takeaways from Research

- **Stigma and low mental health literacy are barriers for every group.** Stigma appeared as a barrier across all three groups, and two reviews called for education to raise awareness of mental health and how to get help.[6,8,10]
- **Bring services to where youth and families already are.** Schools, primary care, and home- and community-based settings reduce travel and stigma and are linked to higher use of services.[8,9,10]
- **Families and trusted relationships matter.** Involving caregivers and peers, and building strong relationships between youth and providers, supports continued engagement in services.[6,8]
- **Coordination across systems is needed.** Youth involved in the court often interact with several systems at once, and services that link them help youth avoid falling through the cracks.[7,8]

Strategies Higlighted by the Research

1. Link court services with mental health care

What is it? Formal partnerships between probation and mental health providers, including routine mental health screening, facilitated referrals, and team-based care coordination such as wraparound.[7]

Evidence base/Example programs: **Project Connect** is a program that involves cooperative agreements between probation and mental health services, systematic screening, facilitated referrals, and training for probation officers. Across four New York state counties, youth who underwent the program were **2.7 times as likely to access services** than comparison youth.[10]

The **Connections program** in Washington state is a wraparound program where each family works with a team that includes a mental health care coordinator and a probation counselor. Youth in this program were less likely to recidivate and served less detention time than comparison youth.[11]

2. Pair diversion with community-based treatment

What is it? Diversion programs offer alternatives to formal court processing, typically for first-time offenders, and often provide treatment in place of sanctions.[7]

Evidence base/Example programs: A meta-analysis of 28 studies found that diversion alone did not significantly reduce reoffending, but results were promising when diversion plans included evidence-based treatments.[12] Ohio's **Behavioral Health/Juvenile Justice (BHJJ)** initiative showed improvements in both delinquency and behavioral health outcomes.[13]

3. Offer mental health services in schools and primary care

What is it? Mental health screening, brief treatment, and care coordination delivered in schools or doctors' offices, sometimes with a mental health professional on site and psychiatric consultation available to the doctor.[8]

Evidence base/Example programs: School-based services and integrated care have linked to higher use and acceptability of services.[9] For low-income families, recommended steps include routine screening, care coordination, family navigators, and consultation lines that support doctors in treating common mental health concerns.[8] Washington state's **Partnership Access Line (PAL)** provides this type of consultation to primary care providers.

4. Use telehealth to supplement, not replace, in-person care

What is it? Mental health care delivered by video or phone, which reduces travel time and widens the pool of providers.

Evidence base/Example programs: The review of children's mental health policies found no studies evaluating the effectiveness of telehealth policies, so evidence is still limited.[9] A systematic review of rural and remote youth found that youth preferred to access mental health services in person over telehealth.[14] However, youth still viewed telehealth as a valuable addition to in-person care, especially when travel times were long. Asking youth and families which option they prefer may improve engagement.

5. Address stigma and involve caregivers and peers

What is it? Education for youth, families, and staff that explains mental health and how to get help, paired with deliberate efforts to include caregivers and peers in a youth's care.[6,10]

Evidence base/Example programs: Two reviews recommended raising mental health literacy and reducing stigma around mental health care.[6,10] One of these reviews also recommended drawing on caregivers and peers as sources of support.[6]

Washington State Resources

- **Wraparound with Intensive Services (WISe):** Team-based, home- and community-based care for youth age 20 or younger on Apple Health with complex behavioral health needs. Youth involved in multiple systems, including juvenile justice, can be referred for a WISe screen. The Health Care Authority keeps a list of WISe providers by county.
- **Mobile Response and Stabilization Services (MRSS):** Youth and family crisis teams that respond in person and can provide in-home stabilization. Quality Behavioral Health is the listed youth provider for Garfield, Asotin, and Whitman counties.
- **Washington's Mental Health Referral Service for Children and Teens:** A free, state-funded phone service operated by Seattle Children's that finds outpatient providers matched to a youth's needs, location, and insurance, including telemental health options. For families on Apple Health, matches are also sent to Apple Health case managers. Families can call 833-303-5437; teens 13 and older can call for themselves.
- **Partnership Access Line (PAL):** Free mental health consultation for primary care providers on diagnosis, medication, and treatment planning, which supports mental health care in local clinics.
- **Telehealth coverage through Apple Health:** Apple Health covers behavioral health services delivered by telehealth, including audio-only (phone) visits, which may help families without reliable internet.

Funding & Support

This brief was completed as part of a project funded by the William T. Grant Foundation and is a joint effort of the HEDCO Institute for Evidence-Based Educational Practice at the University of Oregon and Johns Hopkins University. All information provided is the viewpoints of the brief authors and do not reflect the official views of the University of Oregon, Johns Hopkins, or Project LINK. For more information, please email linkproject@uoregon.edu.

Methods

Findings presented in this brief come from a literature review of academic peer-reviewed studies, as well as reports from non-partisan think tanks, foundations, and county and state program websites. Given the rapid nature of this search, other relevant studies may exist. In addition, please note that we did not use formal statistical methods for summarizing results and exploring reasons for differences in findings across studies.

References

1. Beaudry, G., Yu, R., Långström, N., & Fazel, S. (2021). An updated systematic review and meta-regression analysis: Mental disorders among adolescents in juvenile detention and correctional facilities. *Journal of the American Academy of Child and Adolescent Psychiatry, 60*(1), 46–60. https://doi.org/10.1016/j.jaac.2020.01.015
2. White, L. M., Aalsma, M. C., Salyers, M. P., Hershberger, A. R., Anderson, V. R., Schwartz, K., ... & McGrew, J. H. (2019). Behavioral health service utilization among detained adolescents: A meta-analysis of prevalence and potential moderators. *Journal of Adolescent Health, 64*(6), 700-708. https://doi.org/10.1016/j.jadohealth.2019.02.0103
3. Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science, 4*(5), 463–467. https://doi.org/10.1017/cts.2020.42
4. Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among US children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*(9), 1548–1555. https://doi.org/10.1176/appi.ajp.159.9.1548
5. Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology, 69*(2), 115–126. https://doi.org/10.1002/jclp.21951
6. Babovič, M. (2025). Perceptions of Mental Health, Mental Health Needs and Access to Mental Healthcare Among Justice-Involved Young People: A Systematic Review of Qualitative Evidence. *Criminal Behaviour and Mental Health, 35*(4), 206-227. https://doi.org/10.1002/cbm.70007
7. Zajac, K., Sheidow, A. J., & Davis, M. (2015). Juvenile justice, mental health, and the transition to adulthood: A review of service system involvement and unmet needs in the U.S. *Children and Youth Services Review, 56*, 139–148. https://doi.org/10.1016/j.childyouth.2015.07.014
8. Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics, 139*(1), e20151175. https://doi.org/10.1542/peds.2015-1175
9. So, M., McCord, R. F., & Kaminski, J. W. (2019). Policy levers to promote access to and utilization of children's mental health services: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(3), 334–351. https://doi.org/10.1007/s10488-018-00916-9
10. Gunlicks-Stoessel, M., et al. (2025). Scoping review: Perceived needs, barriers, facilitators, and satisfaction with access and utilization of mental health services among rural adolescents and parents in the United States. *JAACAP Open, 3*(4), 835-838. https://doi.org/10.1016/j.jaacop.2025.06.008
11. Pullmann, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using wraparound. *Crime & Delinquency, 52*(3), 375-397. https://psycnet.apa.org/doi/10.1177/0011128705278632
12. Schwalbe, C. S., Gearing, R. E., MacKenzie, M. J., Brewer, K. B., & Ibrahim, R. (2012). A meta-analysis of experimental studies of diversion programs for juvenile offenders. *Clinical Psychology Review, 32*(1), 26-33. https://doi.org/10.1016/j.cpr.2011.10.002
13. Kretschmar, J. M., Butcher, F., Flannery, D. J., & Singer, M. I. (2016). Diverting juvenile justice-involved youth with behavioral health issues from detention: Preliminary findings from Ohio's Behavioral Health Juvenile Justice (BHJJ) Initiative. *Criminal Justice Policy Review, 27*(3), 302-325. https://doi.org/10.1177/0887403414560885
14. Mseke, E. P., Jessup, B., & Barnett, T. (2023). A systematic review of the preferences of rural and remote youth for mental health service access: Telehealth versus face-to-face consultation. *Australian Journal of Rural Health, 31*(3), 346–360. https://doi.org/10.1111/ajr.12961