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Issue Brief – No. 805
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Mental Health and Juvenile Justice: Moving Toward More Effective Systems of Care

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OVERVIEW — *This issue brief discusses the mental health needs of youth who are involved with the juvenile justice system, how they come into contact with the system, and the evidence of the availability and quality of mental health services for such youth. The paper also explores public policy options for avoiding dependence on the juvenile justice system as a last resort for treating youth with mental disorders.*

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Interviews with mental health experts, correctional officials, and parents, along with media reports and congressional investigations, confirm that the juvenile justice system is being used as a system of last resort for many children with mental disorders. The consensus is that these children would be more effectively served in the community, and that mental health services provided by the juvenile justice system are inadequate to meet the need. Available evidence suggests that more than 70 percent of the children in the juvenile justice system have a mental health disorder and approximately 20 percent have a serious mental illness.[1]

These children with mental health disorders land on the doorstep of the juvenile justice system in a number of ways. Some parents have their children arrested for minor infractions because they cannot find or afford mental health care and the child's behavior has begun to threaten his or her personal safety and that of the family. Other children get arrested on their own by committing minor offenses, such as drinking in public and vandalism. Still other children have committed serious crimes that most agree require secure placement in the justice system.

Two major, government-level investigations in particular have triggered the concerns of federal policymakers. A 2003 study by the General Accounting Office (GAO, now called the Government Accountability Office) found that some 9,000 families relinquished custody of their children to the juvenile justice system for the sole purpose of accessing mental health services they could not otherwise find or afford.[2] An ongoing series of investigations conducted by the Justice Department uncovered severe physical and sexual abuses of youth in juvenile detention facilities, and also found that mental health services were frequently unavailable or inappropriate to meet the need in these facilities.[3]

These reports have shed light on serious flaws in the child mental health delivery system in the United States: missed opportunities for early intervention by other systems (education, public mental health, Medicaid, private insurance); an underdeveloped system of community-based care needed for children with serious mental disorders to stay out of institutions; a juvenile justice system unequipped to handle the demand for mental health care, which in certain areas is even unsafe to house these children. In a "get tough" political climate toward crime,

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these reports have also revealed the challenges policymakers face in garnering political support to improve mental health care for a population of children whose behavior is delinquent.

The issues have raised many questions for which there are little, if any, large-scale data to support answers. Exactly how many mentally ill children are in the juvenile justice system? How many entered that system because they could not get help earlier? What kind of mental health care do they get once in the system? How many of them would have ended up in juvenile justice despite receiving adequate attention from other agencies?

While efforts are being made to answer these questions, lawmakers are beginning to take action. There is widespread agreement that many youth involved in the justice system are experiencing mental illnesses; that public policies should not be designed so that incarceration is a solution for receiving mental health care; that many children who have committed minor offenses would be more effectively served in the community if such care were available; and that youths with mental illnesses who pose a danger and need to be incarcerated should receive adequate treatment so they can function upon release.

A number of efforts are under way at the local, state, and federal levels to improve these circumstances. Strategies are being developed to beef up the infrastructure of community-based care so that children's problems will be detected and treated early on—and that they will have a better chance of avoiding the juvenile justice system. For those who do meet with the system, new screening and assessment tools are being used by police officers, juvenile courts, and detention facilities to identify children's mental health problems. Programs are being tested that would help divert children from detention halls to community-based programs. And there is increasing attention to the quality of mental health care for those who must be incarcerated. These efforts, which require bureaucratic creativity and agency collaboration, hold lessons for wide-scale policy improvements.

This issue brief describes the mental health needs of children who come into contact with the juvenile justice system, how they fall into the system, and what is known about the adequacy of mental health care for justice system–involved youth. It also examines policy options for preventing the incarceration of youth with mental disorders.

MENTAL HEALTH PROFILE OF YOUTHS WHO ENCOUNTER THE JUVENILE JUSTICE SYSTEM

Some general comments can be made about the youth who come into contact with the juvenile justice system. They are likely to be minorities (blacks and Hispanics comprise 68 percent of youth in detention halls

and training centers) and from low-income families. Generally, their demographic profiles suggest they do not have adequate health care insurance coverage.[4]

Prevalence of Disorders

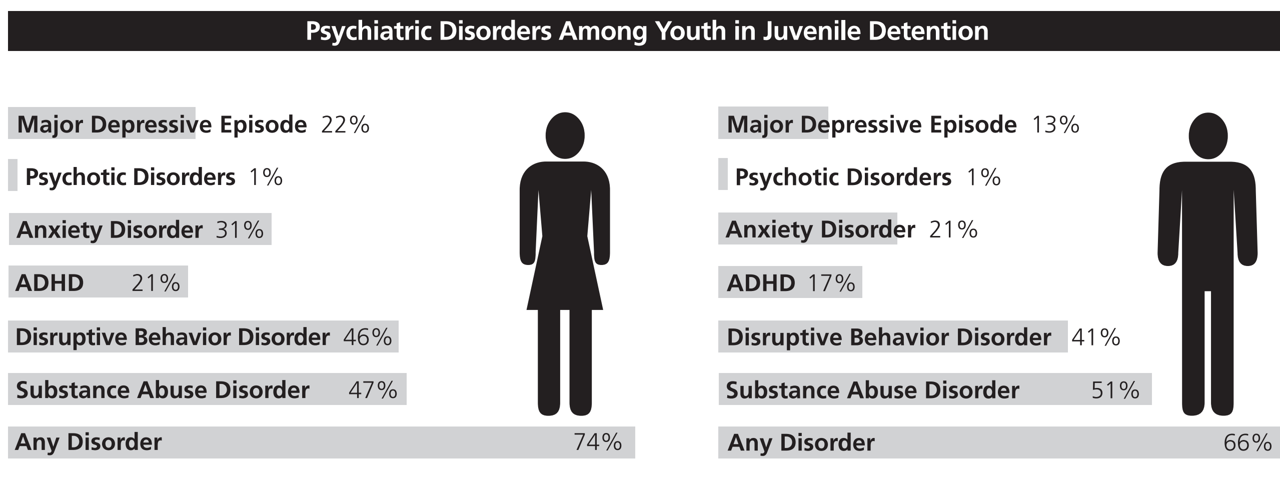
When it comes to understanding the prevalence, as well as the severity, of mental disorders among these children, policymakers have little data to go on. The federal government does not collect such information. Smaller-scale studies have revealed, however, that the prevalence of mental disorders among children in the juvenile justice system is much larger than that of the general child population. Nearly two-thirds of males and three-quarters of females in the juvenile justice system have at least one psychiatric disorder, compared with about 20 percent of all children (Figure 1).[5] This means that they meet criteria established by the American Psychiatric Association as having behaviors outside the norm, largely caused by chemical or neurological imbalances.

Types of Disorders

One major study conducted in 2002 found that half of males and almost half of females in the juvenile justice system had a substance abuse disorder, 11 percent of both sexes had attention deficit hyperactivity disorder (ADHD), and 11 percent of males (20 percent of females) had major clinical depression. In addition, more than 40 percent had a disruptive disorder—either oppositional defiant disorder, which manifests

FIGURE 1

Psychiatric Disorders Among Youth in Juvenile Detention



Source: Table 2 of L. A. Teplin et al., *"Psychiatric Disorders in Youth in Juvenile Detention,"* Archives of General Psychiatry, *59, no. 12, (December 2002): 1136.*

early in childhood, or a conduct disorder, which often emerges later.[6] Both disorders are characterized by antisocial behavior, fighting, and disrespect for rules. Behavior is more severe with a conduct disorder.

Disruptive and conduct disorders are thought to be caused by a combination of genetic vulnerability and negative environmental factors, such as poverty, parental neglect, marital discord, parental illness, or parental alcoholism. Adolescents with a conduct disorder have been found to have impairment in the frontal lobe of the brain, an area that affects the ability to plan, to avoid harm, and to learn from negative consequences.[7] Another study found that 11 percent of juvenile detainees met criteria for post-traumatic stress disorder and that more than half had witnessed violence that precipitated their trauma.[8]

Severity

Some studies have found that about 20 percent of children in the juvenile justice system have serious mental disorders—sometimes one, but usually a combination of conditions (for example, bipolar, ADHD, schizophrenia, disruptive disorder) that severely impairs their ability to function in their families, schools, and communities. Their disorders lead them to be noticeably disruptive or withdrawn.[9] Often, child abuse has exacerbated their condition(s). An estimated 25 to 32 percent of youth in the juvenile justice system have been either physically or sexually abused.[10]

A number of studies have found that children with serious mental disorders in the juvenile justice system resemble similarly diagnosed children in the public mental health system. Both groups of diagnosed children are characterized by similar rates of committing minor crimes, failing in school, being disruptive, being poor, and suffering family trauma.[11]

ENTERING THE SYSTEM

There are no systematic data to map and quantify the different routes by which children with mental disorders enter the juvenile justice system. Some enter because they are in crisis, because there are no privately or publicly funded inpatient beds that are available or affordable, or because their parents are encouraged to press charges for minor infractions in order to place their children in a supervised setting. Surveys indicate that parents are told their children will get the mental health services they need in the juvenile justice system.[12]

Many (whose disorders may or may not have been identified) have committed nonviolent crimes and are arrested without their parents' help. Although there are no national data on the types of crimes committed by youth with mental disorders, some regional surveys are available. For instance, the Texas Youth Commission found that, in 1995, 67 percent of offenses by mentally ill children were not violent.[13]

A minority of children in the juvenile justice system have committed violent crimes that most agree require incarceration. Data are scarce on the proportion of incarcerated youth with mental disorders who have committed violent crimes (murder, rape, robbery, aggravated assault). Among the overall juvenile detainee population, the Department of Justice (DOJ) in 2001 reported that 16 percent of all crimes committed by juveniles were violent.[14]

Custody relinquishment for the sole purpose of accessing mental health care is an issue of concern to policymakers. In 1999, a survey released by the National Alliance for the Mentally Ill found that 20 percent of parents of children with serious mental disorders were told by authorities that they needed to relinquish custody to either the child welfare or juvenile justice systems to get the intensive mental health services their children needed.[15] In these cases, families know that their children have a serious mental disorder and are unable to find—or afford—mental health care. A number of reports have established a direct connection between lack of access to community-based services and entry into, or detention within, the juvenile justice system. In cases where a child's behavior has become so disruptive that he or she requires supervised care, placing the child with juvenile justice may appear to be the only way to access such services. When available, residential treatment or inpatient psychiatric care is free, if ordered by the courts. In some areas, judges can get preference for community-based beds in residential treatment centers (RTCs) or hospitals when there are waiting lists.

In April 2003, GAO reported that at least 12,700 families relinquished custody of their children for the sole purpose of trying to gain mental health services for them.

In April 2003, GAO reported that at least 12,700 families relinquished custody of their children for the sole purpose of trying to gain mental health services for them. Many of these families did not qualify for Medicaid, which offers the most comprehensive array of services these children need to stay at home. Most often, these families did not have private insurance that covered such services, or they had exhausted their annual coverage limits. In about 9,000 of these instances, children went to the juvenile justice system. The rest were placed in the child welfare system, where they immediately qualified for Medicaid.[16]

A 2004 congressional study offered some insight into how the juvenile justice system is acting as a way station for many children who cannot access community-based mental health care. It found that two-thirds of juvenile detention facilities hold youth who are waiting for such treatment. In many instances, these youth had committed minor offenses and judges ordered them to be placed in a psychiatric hospital unit, RTC, or outpatient care, but nothing was available. They remained in detention halls until a slot was open. Over a period of six months, according to the report, nearly 15,000 incarcerated youth were waiting for community mental health services to become available, representing 7 percent of all youth in juvenile detention.[17]

The Systems Shuffle

A 2002 report on the California Juvenile Justice system aptly describes how many children with mental disorders come to the juvenile justice system after failure in dealing with other systems:

> "We are looking at a population who unfortunately seem to have a career pathway through the multiple public service systems, with the ultimate destination of the juvenile justice system. This career pathway begins with the identification of mental health needs by a child care teacher at age 5. It continues with a referral for special education at age 7, interaction with mental health and child welfare at age 9, and inpatient psychiatric hospitalization at age 12. The career pathway ends with involvement in the juvenile justice system at age 14. Not only does this alarming pathway point to the many failed opportunities for intervention…it also shows that by the time a youth reaches juvenile probation, he/she is likely to have experienced years of abuse, neglect, trauma, poverty, failed services, and institutional bias."[18]

Although the special education system is mandated to serve children with serious mental disorders, they are frequently unidentified or mislabeled as learning disabled and miss the opportunity to receive care early on. Private insurance plans contain coverage limits and gaps for both institutional and community-based care. States also vary in the extent to which Medicaid pays for community-based care. (Difficulties in funneling public and private insurance to support community-based services make it difficult for states to expand these systems.) For a more detailed discussion, please see "Children with Mental Disorders: Making Sense of Their Needs and the Systems That Help Them."[19]

The public mental health system, which serves lower-income children, provides a rich array of services in some communities but is not specifically mandated to serve children and has recently cut many services due to state budget shortfalls. State public mental health budgets are usually not large to begin with; they most often pale in comparison to child welfare, Medicaid, and juvenile justice budgets.

Child welfare and juvenile justice are considered systems of last resort for children with serious mental disorders. Although the child welfare system is required to serve abused and neglected children, including those children whose parents voluntarily place them, it is not always the final stop for children with serious mental disorders—especially those who are misbehaving. "As a kid becomes more delinquent, child welfare tends to hand them off to juvenile justice," says Ned Loughran, executive director of Council of Juvenile Correction Administrators. "Sometimes they get so frustrated in working with the kid, they'll help the parents get the kid [criminally] charged….The shuffle happens when one agency washes their hands of a child. The problem is, when they all wash their hands, a judge says, 'They're going to corrections.' There they have to be served."[20]

Underdeveloped Infrastructure

Although states, the federal government, and localities have begun to provide community-based mental health care for these children, available evidence indicates that these systems are underdeveloped in many areas. Again, no national data exist on the adequacy of community-based care for children with serious mental disorders. But news reports and numerous studies, including the Surgeon General's *Report on Mental Health*, point to a shortage of both outpatient community-based care and inpatient beds for children. Overall, for adults and children, the number of inpatient psychiatric beds per capita has dropped by 62 percent since 1970. Declines have been most dramatic for publicly run (state and county) facilities, which have closed 89 percent of inpatient psychiatric beds per capita.[21]

The Children's Services Program helps communities provide a range of intensive home-based services to help children avoid being institutionalized.

It is difficult to quantify how much of the placement of children in the juvenile justice system is attributable to a shortage of inpatient beds, or to a shortage of outpatient care that is placing too much demand on inpatient slots. As noted by the President's New Freedom Commission on Mental Health, there are no national data assessing the types of community-based services that may be in short supply. Nor is there a national consensus on the number of mental health inpatient beds that are needed to complement an ideal community-based system of care for children.[22]

To begin to address the dearth of community-based services for children with serious mental disorders, SAMHSA has been running the Children's Services Program since 1997. The program gives communities grants in order to build the infrastructure to provide a range of intensive home-based services to help children avoid being institutionalized. In fiscal year 2004, the Children's Services Program operated in 40 to 60 communities at an annual budget of $102 million. During the calendar year 2004, it served 6,000 of a pool of 3 million eligible children.[23]

Medicaid's Role

The details of Medicaid implementation reveal the program's untapped potential to be a larger funder of community-based care. They also suggest how barriers to states' and providers' use of Medicaid have stymied growth of the community-based infrastructure. About 20 percent of all children with a mental health problem are publicly insured, mostly through Medicaid.[24] In 1998, Medicaid covered 24 percent of all children's mental health expenditures.[25]

Compared with most private insurance plans, Medicaid provides the richest array of benefits needed by children with serious mental disorders to remain at home. Under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, children are entitled to any

service needed to treat a condition as long as it is deemed medically necessary. (In practice, numerous studies have documented that EPSDT is unevenly implemented, and that many children fail to receive the services to which they are eligible.) Although EPSDT entitles children to necessary health care, receiving such care can be complicated, particularly when the services are not generally covered under a state's Medicaid plan.

Many states do not define the services available under their state Medicaid plans, leaving providers unsure whether the state will reimburse them and parents unsure what services are available.

A major stumbling block for families seeking Medicaid coverage for children with serious mental disorders is that a number of states do not define, or list, the services available under their state Medicaid plans. This is far more often the case for intensive community-based services than for residential care. Without definitions, there are no billing codes or payment rates for providers to use, leaving providers unsure whether the state will reimburse them and parents unsure what services are available. "Unless a service is in your state plan, it becomes debatable about which of them are covered," says Janet Schalansky, former Medicaid director in Kansas.[26] According to a 1999 report released by the Bazelon Center for Mental Health Law, "Families are then left to fight, service by service, treatment by treatment, for the care their child needs."[27]

The Bazelon report documented how many state Medicaid plans define services for both Medicaid fee for service and managed care arrangements (most Medicaid children with serious mental disorders are in fee for service care). Among the range of intensive community-based services most helpful to children with serious mental disorders, the report found that child respite care was listed as a covered service in only 11 states; family support was listed in 19 states. More commonly defined services were therapeutic foster care (20 states), independent living skills training (30 states), and school-based day treatment (30 states). Although not universal, the most frequently defined benefits listed in this area were day treatment outside of schools (42 states), targeted case management (42 states), and intensive home-based services (35 states).[28]

Residential services such as care in hospital psychiatric beds or RTCs were defined by most, but not all, Medicaid plans. Ninety percent of programs defined hospital services; 31 states listed RTCs. (The vagueness of Medicaid state plans has confused some residential treatment facility operators. Advocates in some states report that RTCs will not accept Medicaid children unless custody has been relinquished to either child welfare or juvenile justice—systems they are sure will pay them.[29]) Only 20 states listed coverage for therapeutic group homes (small settings of 16 or fewer beds), and 40 percent of Medicaid plans defined residential crisis programs (in lieu of hospital placement) as a benefit.

LAST STOP: JUVENILE JUSTICE

Since 1899, with the launch of the first juvenile court by social reformers in Chicago, the juvenile justice system has operated with a distinctly different set of goals than the criminal justice system for adults. Based on the civil law doctrine of "parens patriae" (state as parent), juvenile courts were designed primarily not to punish, but to act in the best interests of children. As an Urban Institute paper notes, the court was set up "to investigate the factors that caused youth to go astray and then devise a package of sanctions and services that would set them back on the right track."[30] Mental health services are part of this package.[31]

Shifting Goals

During the last two decades, however, experts have noted that a "get tough" attitude on crime has permeated the juvenile justice system, as state legislatures have taken a number of measures to move children through the adult court system. Many of these actions came on the heels of rising juvenile violent crime rates. Between 1980 and 1994, arrest rates for juvenile violent crimes increased by 62 percent.[32] By the end of the 1990s, nearly all states enacted or expanded laws that gave juvenile court judges discretion to transfer certain cases to adult court. (In 1960, only half of all states had these laws in place, and transfer cases typically involved serious and violent crimes). A number of states also passed laws that required judges to transfer certain categories of crimes, as well as youths with certain prior arrest records, to adult court.

The greatest impact on juveniles being tried as adults has been state laws that lower the age at which youths can be tried in adult courts. As of 1997, ten states excluded all 17-year-olds from juvenile courts; another three states excluded all 16-year-olds. About 220,000 law violations committed in 1996 by youths under 18 were excluded from juvenile court because of such age limits. One of the effects of these laws has been that violent offenses are no longer the primary cases being transferred to adult court. At least half of the youths transferred to the adult court system have committed property and drug offenses. (Interestingly, trends in youth violent crime have recently reversed. The juvenile violent crime arrest rate in 2002 was at its lowest level since 1980—47 percent below the peak rate of 1994—according to the National Center for Juvenile Justice.[33])

These data are startling to many because some children are being sent to adult prisons for relatively minor crimes. "The downside to children who are processed as adults is that they get mixed in with all of the adults in jail and prison," says Joe Cocozza, director of the National Center for Mental Health and Juvenile Justice. "But there is some argument in the field that they'll probably end up getting better access to mental health services and evaluation. At the adult level, in jails and in facilities, there

are typically more mental health services, and more of a history of services, than at the juvenile level. Unfortunately, the services are geared towards adults, not children."[34]

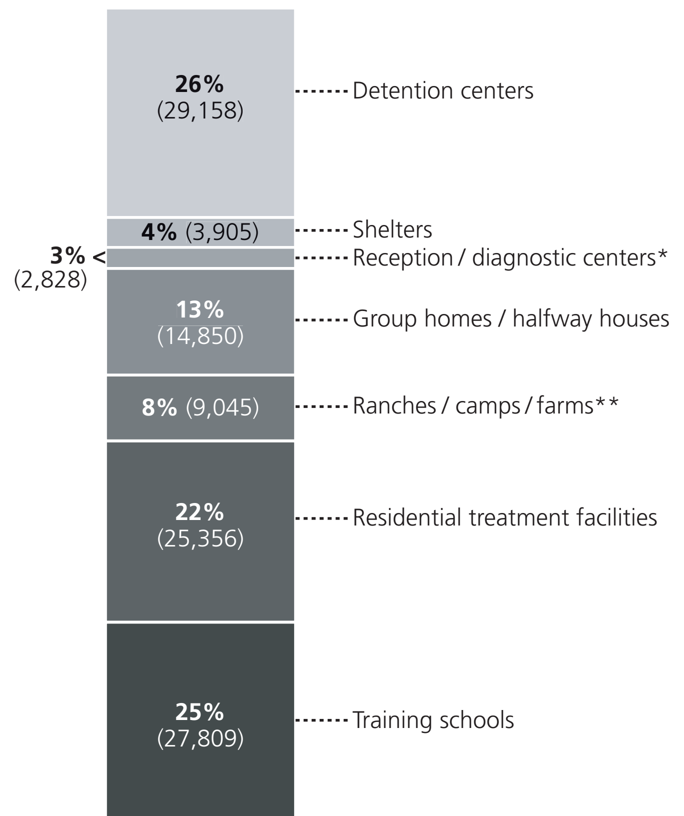
The Process

On any given day, about 100,000 children are housed in juvenile justice facilities, including detention centers, halfway houses, residential treatment facilities, and training schools (youth prisons) (Figure 2). About 25 percent are in detention centers (youth jails) awaiting trial. About 22 percent have been ordered by judges to secure residential treatment facilities for mental health care. Thirteen percent have been ordered to halfway houses: low-security group homes that allow youth to attend school and jobs. Another 25 percent are serving terms in training schools for more serious crimes.[35] Most incarcerated youth have committed property crimes, drug offenses, and public disorderliness offenses. About 16 percent have committed violent crimes.[36]

Entry into the juvenile justice system usually starts with an arrest. Cases referred to juvenile court are first screened by an intake department, which decides whether to dismiss the case or resolve it formally or informally. If it is determined the case should be handled formally, a petition is filed and the case is placed on the court calendar for a hearing. Whether youths are placed in a detention center awaiting the hearing rests on a number of factors, including their prior record, the seriousness of the offense, and whether a parent or guardian is able and willing to keep them until trial.

At the hearing, the judge decides the most appropriate sanction, generally after reviewing a report by the probation department that includes the child's family circumstances and prior behavior. Judges choose from a range of options that typically includes committing the youth to a juvenile justice institution; placing them in a group or foster home; probation; referring them to an outside agency, day treatment, or mental health program; or imposing a fine or community service. In 2000, 63 percent of youth were placed on formal probation after a trial.[37]

FIGURE 2
Distribution of Incarcerated Youth Among Juvenile Justice Facilities, by Percentage and Number of Youth



* *A short-term facility that screens youth who have been judged delinquent if they are in need of further evaluation to help in the assignment of a residential placement.*

** *A long-term placement for youth whose behavior does not merit the more prison-like environment of a training school. These are generally in counties, not local communities. Status offenders are unlikely to be in these facilities.*

Source: Center for Mental Health Services, Inventory of Mental Health Services in Juvenile Justice Facilities, 1998. Note that percentages do not add to 100 percent, due to rounding.

Access to Mental Health Care

A number of studies have found that access to mental health care for youth in the juvenile justice system—whether detained until trial, on probation, or placed in group homes or in more restrictive facilities—varies by region and is often inadequate.

In a series of investigations, the DOJ Civil Rights Division found many problems with more than 100 juvenile correctional facilities across 16 states. The probe began in the 1990s during the Clinton administration and continued aggressively under the supervision of former Attorney General John Ashcroft. DOJ launched the investigations after media reports and complaints from parents and lawmakers brought attention to wide-scale abuses that were occurring in juvenile justice facilities due in part to severe overcrowding. Between 1984 and 1995, the number of juveniles held in secure facilities increased by 72 percent. The proportion of juveniles held in overcrowded facilities increased from 20 percent to 62 percent.[38]

The findings were alarming and included reports of dirty facilities, the raping and beating of juvenile detainees by correctional employees, and violence among delinquents. With regard to mental health care, investigators found inadequate or no screening practices, a shortage of clinical services, misuse of medications, and failure to prevent or respond to suicide attempts.[39] DOJ filed suits alleging the constitutional violation of minors in a number of states (including Mississippi, Louisiana, Georgia, and Kentucky) and demanding that the states take various actions to improve conditions.[40]

Other studies have found a dearth of detention, probation, and parole officers who are trained to identify and treat mental disorders.[41] One study conducted by the Office of Juvenile Justice and Delinquency Prevention found that 75 percent of juvenile facilities do not meet basic suicide prevention guidelines.[42]

Considerable attention has been given to mental health screening protocols in the juvenile justice system, which are the first steps toward identifying mental health needs among these children and may influence the type of treatment or sanction a judge will order. One 1992 study found that, in many states, youths did not receive a needs assessment until after they were sentenced to a correctional facility, that only one-third of all states used a formal needs assessment instrument, and that the quality of needs assessment varied enormously.[43]

Progress has been made since then, although gaps still exist. The MAYSI-2 (Massachusetts Youth Screening Instrument, 2nd Edition) is a self-reporting survey designed to assist juvenile justice facilities in identifying 12- to 17-year-olds with mental health needs. It is intended for use at any point in the juvenile justice system. According to the National Center for Mental Health and Juvenile Justice, it is currently being used in 49 states, with 35 states indicating they will implement the MAYSI-2 statewide in one or more parts of their juvenile justice system.

The most recent federal survey of mental health services available in the juvenile justice system was conducted by SAMHSA's Center for Mental Health Services in 1998. It found that 94 percent of facilities (ranging from detention centers to halfway houses to training schools) provide some type of mental health services—mainly in the form of medication, emergency services (to help prevent suicide), and therapy. But services varied depending on the type of facility.[44]

Detention centers are the initial holding centers for youth awaiting trial, and are thus likely to be the first facility with which youth come into contact. According to the SAMHSA study, 71 percent of detention centers provided screening and 56 percent provided more comprehensive evaluations. Eighty-five percent of such facilities provided emergency services.[45] (Some advocates claim these figures are misleading. They argue that having someone available to provide mental health care does not necessarily indicate that the care is adequate, or that all children in need of services are referred to care.)

Funding and Coordination Problems

According to the National Center on Mental Health and Juvenile Justice, lack of mental health care in the correctional system often stems from funding shortfalls due in part to under-funded government programs and to confusion among juvenile justice, child welfare, and mental health systems over who should be paying for care.[46] To be clear, the law does not create an entitlement for youth within the juvenile justice system to receive mental health services. The law strongly encourages states to use their funding for a variety of purposes, including the provision of mental health services. According to the regulations of the federal Office of Juvenile Justice Delinquency and Prevention (OJJDP, an arm of the DOJ), state plans should contain "a plan for providing needed mental health services to juveniles in the juvenile justice system, including information on how such a plan is being implemented and how such services will be targeted to those juveniles in such system that are in greatest need of such services."[47]

Unlike children in the child welfare system, Medicaid does not pay for health care for inmates of detention centers and correctional facilities.

The Juvenile Justice system funds mental health services predominately with state and local funding, some of which comes from federal grants. States may tap into a number of fixed funding sources provided by the OJJDP. For instance, in FY 2004, OJJDP distributed $83.2 million in formula grants to states, some of which could be used to fund mental health services if states so chose. Juvenile Accountability Incentive Block Grants, awarded to states on the condition that 75 percent of the money be passed on to localities, are another source. State challenge grants are also available to any state that qualifies for formula grants. Unlike children in the child welfare system, Medicaid does not pay for health care for inmates of detention centers and correctional facilities. Juvenile justice officials

say their inability to tap into Medicaid funding impairs their efforts to fund an adequate array of mental health services.

Depending on the locality, mental health and child welfare agencies are dependent on the strength of local budgets to assist the juvenile justice system in providing mental health care. SAMHSA reports that, in 1998, 47 percent of juvenile justice facilities (excluding group homes and halfway houses) received some assistance from mental health agencies in order to provide mental health services. (In many instances, mental health agencies run screening, evaluation, and treatment programs in detention centers.) Forty percent received some help from child welfare agencies. But efforts to share funds and personnel are frequently constrained by money problems. A SAMHSA report states, "Different systems may recognize their joint responsibility to young people, but tight budgets at the local levels, where pooled or blended funding does not exist, reinforce turf wars."[48]

Transitioning Care

Children coming into the juvenile justice system are disproportionately from low-income families, and, as such, many are enrolled in Medicaid prior to arrest. While serving time in juvenile correctional facilities, their Medicaid eligibility is often terminated, and they experience an interruption in coverage upon release, having to reapply for Medicaid and wait an average of 45 to 90 days for reinstatement. This is a particular problem for youth with schizophrenia, bipolar disorder, depression, and other conditions who require medication to remain functional. Under federal rules, states do not receive federal Medicaid matching funds for inmates in detention centers, jails, and correctional facilities. States have the flexibility under Medicaid to continue enrollment for inmates while suspending benefits, but according to the Bazelon Center for Mental Health Law, most states opt to terminate enrollment.[49]

PROMISING STRATEGIES

Numerous studies suggest that the 4 million children in the United States with serious mental disorders have a high likelihood of colliding with the juvenile justice system if their conditions are left untreated. Over the past three decades, government-supported mental health systems have begun to implement a system of care designed to give children and families the skills and support they need to stay at home. Services include individual therapy, behavioral coaches, family education and training, respite care for parents, around-the-clock crisis response, and school-based and recreational services including therapeutic summer camps.[50]

Mental health experts and children's advocates acknowledge that institutionalization is sometimes unavoidable and appropriate when such children pose a clear threat to their own safety or to that of others. However, RTCs and psychiatric hospitals, they believe, should be used as a last resort and as a short-term fix until children are stabilized and can return home.

Evidence on the effectiveness of residential treatment is discouraging. Whether placed in group homes, psychiatric hospitals, RTCs, or training schools, children's behavior generally does not improve after they are released back to their homes. Researchers say these findings are understandable, given that residential settings make work with family members inconvenient and do not teach children how to cope with everyday life.[51] Some studies have found that the poor behavior of youth in residential facilities is actually reinforced through interaction with other troubled residents.[52]

Residential treatment is also expensive. Inpatient psychiatric care costs an average of $400 to $550 per day. It is commonly used as a short-term solution (12 to 30 days) to stabilize a child's condition while plans are made for longer-term treatment in the community or in RTCs.[53] Stays in RTCs frequently run between 12 and 18 months. Annual costs for RTCs can exceed $250,000.[54] (See "Infrastructure Development" section for a discussion on Wraparound Milwaukee and comparative costs of outpatient community-based care.) Residential care accounts for a disproportionate amount of national mental health spending. For instance, although used by only about 8 percent of treated children, RTC costs represent nearly 25 percent of the national outlay on children's mental health.[55]

Mental health experts and administrators across child-serving agencies agree that it is preferable to treat children with serious mental disorders outside of institutional settings in general and outside of the correctional system in particular, when public safety permits. A number of states and localities are trying different financing and delivery strategies to accommodate this approach. Some are focusing on identifying and treating children early on in their disease, using Medicaid as a major funder. Others are experimenting with state-funded programs to identify children with disorders at the point of arrest and to divert them, when possible, to community-based services instead of detention. In addition, the federal government has established task forces, and Congress has and is considering legislation, to tackle these issues. (See "Federal Interventions" and Congressional Action" sections below for further discussion.)

Using Medicaid for Early Intervention

Some states are seeking to build, and fund, a system of community-based care to reach families early—before their child's troubled behavior progresses through the familiar pattern of school failure and, ultimately, arrest. For low-income children, Medicaid is one option for financing an array of family support systems, medications, and therapies that children with serious mental disorders need in order to stay at home. As stated earlier, a number of states are already ensuring that their Medicaid programs will fund these services by specifically listing them in their state Medicaid plans. No special waivers are required to do this.

Other states are using Medicaid to provide such services to families regardless of their income levels. Under current law, Medicaid will pay for services to children with mental disorders whose family income exceeds eligibility, but only if they are institutionalized. (After one month of care in an institution, the income and resources of the child's family are no longer considered, and Medicaid will assume the costs of care.) Most families, however, would rather keep their children at home. Medicaid offers states two options for accomplishing this: the TEFRA option (section 143 of the Tax Equity and Fiscal Responsibility Act of 1982, known as the Katie Beckett option) and home and community-based service waivers.

Currently, ten states are using the TEFRA option to cover home and community-based services for mentally disabled children of all income levels. These are children who would otherwise need care in a hospital or other institution. States using this option must serve all eligible children in the state and must serve children who are physically as well as mentally disabled. The TEFRA option does not require a waiver application. It can be approved by the federal regional office.[56]

Three states (Kansas, Vermont, and New York) have secured home and community-based service waivers to serve children of all income levels who have serious mental disorders. Unlike the TEFRA option, states using these waivers can restrict services to certain categories of disabled children, and can limit enrollment. The Medicaid agency can decide to expand the array of covered services beyond what the program allows, such as providing for family support services. Although states must go through the work of submitting a waiver application to the federal Centers for Medicare & Medicaid Services, the waiver strategy allows a Medicaid agency to limit its budget exposure by providing a set number of slots and restricting enrollment by disability type.[57]

State and Locally Funded Diversion Efforts

A number of localities and states are trying various ways of identifying children with serious mental disorders at the point of arrest or adjudication and diverting them from incarceration to community-based care. The Texas Special Needs Diversion Program, run by the Texas Correctional Office, is one such example. Texas requires that all children not released after arrest be screened for mental health disorders. Children are referred to this program predominately during their court hearing, or afterwards, when they are awaiting placement in the juvenile correctional system. Once in the program, children are allowed to remain at home under the supervision of a two-person team—a therapist and a probation officer. The team coordinates a range of services (including psychiatric services, family counseling, etc.) for the child and family on the basis of individual

Some localities and states are testing ways to identify children with serious mental disorders at the point of arrest or adjudication and divert them from incarceration to community-based care.

need. Most services are provided in school or at home. The probation officer makes unscheduled home visits three times per week; the therapist makes one scheduled home visit per week. Parents or guardians are required to attend group meetings weekly. The program runs four to six months. It is funded by a state appropriation as well as revenue for therapeutic services collected from Medicaid, the State Children's Health Insurance Program (SCHIP), or private insurers. The team processes Medicaid or SCHIP eligibility for youth when they enter the program.

Infrastructure Development: Blending Funding Streams for Diversion

Wraparound Milwaukee is an example of a strategy intended to provide an infrastructure of community-based services for children with serious mental disorders—not early on, but at the point where they are headed for RTCs, in-patient psychiatric wards, or jail.

Wraparound Milwaukee is, in a sense, a diversion program on two levels. It diverts children from institutional to community-based settings, and it also diverts money traditionally spent by child welfare, juvenile justice, and Medicaid systems on institutional care to community care. The program pools funding from the county child welfare, juvenile justice, and Medicaid agencies to pay for community-based services. Savings come from lower rates of institutionalization.

Wraparound Milwaukee was designed to yield better outcomes for children. Before the program was launched, nearly 60 percent of children in residential treatment beds paid for by either child welfare or juvenile justice came back to these agencies' doorsteps within six months of discharge. The program was also designed to save money. Child welfare and juvenile justice were paying an average of $5,000 per child per month for institutional care, whereas community-based care cost $2,800.[58] Medicaid was also racking up costs in readmissions to psychiatric hospitals.

The entry point to Wraparound Milwaukee is through referrals from child welfare and juvenile justice. Both agencies pay a capitated rate for each child referred (which comes to about half of what they would spend on institutional care for each child). Medicaid is also charged a capitated amount for each Medicaid-eligible child served. Other contributions come from the state mental health agency.

The program has yielded improved child outcomes and cost savings. Charged offenses declined from nearly 2 per youth before program involvement to 0.5. Average percentage of school days attended increased from 60 to 85 percent.[59]

The number of days children spent in an inpatient psychiatric hospital went from 5,000 annually when the program started to 240, says program director Bruce Kamradt. Average stays in residential treatment centers

declined from 365 to 80 days. In 1996, child welfare and juvenile justice were serving 370 youths in residential care at a combined cost of $18.4 million. Today Wraparound Milwaukee is serving 630 youths with combined input of $17.7 million from the two agencies.[60]

Why is the program working so well? Shared liability across agencies is a major factor, according to Sheila Pires, health care consultant and former New Jersey Human Services Department official.[61] Traditionally, child welfare and juvenile justice must bear the costs for residential placements. If each agency contributes to a community-based system of care, and the system does not lower residential placement rates, the agencies must still pay for youths coming through their doors that need institutional care. Under Wraparound Milwaukee, each agency pays a capitated amount per child; if costs are higher because residential placements could not be avoided, the managed care organization absorbs the costs.

Using Medicaid for Transitional Care

A number of states are taking innovative approaches to maintaining Medicaid eligibility and, in some cases, benefits, to avoid interrupting care when youths are released from the juvenile justice system. For instance, in Massachusetts, the Department of Youth Services (DYS), which houses the juvenile justice agency, struck an agreement with the state Medicaid agency to maintain Medicaid benefits to incarcerated youth. In other words, DYS reimburses the Medicaid agency for the federal share of payments it cannot collect. Colorado continues Medicaid benefits to youth in detention centers awaiting final disposition, interpreting federal law to mean that the juvenile justice system lacks legal custody of a child until a judge determines his or her sentence. According to the National Center for Mental Health and Juvenile Justice, about a dozen other states are considering a strategy similar to that used in Colorado.[62]

FEDERAL INTERVENTIONS

After release of the New Freedom Commission on Mental Health final report, *Achieving the Promise: Transforming Mental Health Care in America*, the Department of Health and Human Services (DHHS) Secretary called on SAMHSA to review the report with the goal of taking steps to improve the mental health care system.[63] Two interagency task forces were formed. The Federal National Partnership for the Transformation of Children's Mental Health is spearheaded by SAMHSA and includes experts from several DHHS divisions that implement children's programs (Health Resources and Services Administration, National Institute of Mental Health, Office of Minority Health, Centers for Disease Control, and Administration for Children and Families, among them). It also includes officials from the Departments of Education, Labor, and Justice.

A higher-level task force, composed of senior staff members from a variety of federal agencies that serve children, was formed to create an action agenda to improve the mental health system for adults and children. The Federal Partners Senior Workgroup will soon release its action agenda, which will include addressing the problem of child custody relinquishment.

In addition, in 2004 the National Center for Mental Health and Juvenile Justice, in conjunction with SAMHSA, OJJDP, the National Association of State Mental Health Program Directors, and the Council of Juvenile Correctional Administrators, formed a group to create a blueprint for translating the vision of the New Freedom Commission report into steps needed to reform the mental health and juvenile justice systems.

DOJ Efforts

OJJDP has begun a number of efforts to improve mental health care within the juvenile justice system. For example, the Court Coordination Project is an eight-site initiative funded with discretionary monies that works with judges to bring multiple agencies together to help troubled children who come to the attention of the court. DOJ intends to provide three years of funding, according to Karen Stern of the OJJDP.[64]

In addition, effective in 2005, OJJDP's Juvenile Accountability Block Grant, which gives states latitude to fund a variety of goals, includes mental health screening and intervention as a new priority area.

OJJDP is looking to collaborate with other government agencies to beef up the system's ability to provide mental health care. "The issue is these kids are ending up with us because of failures in other systems. It doesn't make sense to tackle this alone. We have to work with SAMHSA and the Department of Education to figure out some strategies to deal with this, and ideally set up some pilot programs. Our administrator is also concerned that we can't get Medicaid to pay for incarcerated children. We would like to launch a pilot to see if Medicaid was available for these kids, would it get them out of the system faster or lower recidivism rates," says Stern.[65]

Significant progress has been made in developing effective interventions to treat children with mental disorders who enter the juvenile justice system.

Evidence-Based Practices

Over the past decade, there has been significant progress made in developing interventions demonstrated to be effective in treating children with mental disorders who enter the juvenile justice system. These models include multisystemic therapy, functional family therapy, and multidimensional treatment foster care. All are short-term programs that work with parents, guardians, and children at home to improve children's behavior, as well as the communication and problem-solving skills of parents and siblings. Services provided often include individual and family therapy, medication management, behavioral coaching, and

respite care. All have shown that they reduce psychiatric symptoms, out-of-home placement, and long-term rates of re-arrest.[66] A number of areas are funding these interventions using monies from programs including Medicaid, public mental health, and child welfare.

CONGRESSIONAL ACTION

The 108th Congress considered a number of bills that would expand community-based systems of care for children with mental disorders, expand Medicaid coverage for these children, and divert mentally ill offenders (some of them children) from prison to community-based care.

Many in Congress, on both sides of the political aisle, were struck by the 2003 GAO report that found at least 12,700 families had relinquished custody of their children for the sole purpose of trying to get them mental health services. Two bills addressing the problem of custody relinquishment were considered. But they ultimately stalled in the 108th Congress.

The Keeping Families Together Act (S. 1704, H.R. 3243) sought to help states create comprehensive systems of care for children with mental disorders by earmarking $55 million over six years to create "Family Support Grants." It was introduced with bipartisan sponsorship in both the House and Senate. To receive the grants, states would have to end the practice of custody relinquishment and cover children's mental health services under Medicaid, SCHIP, or another health program of their choice. The Act would have also established a federal interagency task force to study mental health issues in the child welfare and juvenile justice systems. In addition, it would have required families with children with serious mental disorders to buy into Medicaid on a sliding-scale basis. It was introduced in the House by Pete Sessions (R-TX) and Henry Waxman (D-CA), and in the Senate by Charles Grassley (R-IA) and Edward Kennedy (D-MA). Under the Act, families with private insurance who pay at least half of the total cost of their health care premiums would be able to tap into Medicaid once their private coverage was exhausted, and the Department of Health and Human Services would provide a report to Congress assessing state efforts to address the custody relinquishment problem. Both bills were reintroduced in the 109th Congress (S. 380, H.R. 823).

The Family Opportunity Act (S. 622, H.R. 1811) would have allowed middle-income families with children with serious mental disorders to tap into Medicaid once their private coverage was exhausted. The Act also provided for up to 10 state demonstration projects to test the effectiveness of providing home and community-based alternatives to psychiatric residential treatment facilities. The bills did not become law. They were reintroduced in the House and Senate in the 109th Congress (S. 183, H.R. 1443).

To promote more efforts to divert juveniles from jail, the 108th Congress enacted, but did not fund, the Mentally Ill Offender Treatment and Crime Reduction Act (P.L. 108-732). Sponsored by Sen. Mike DeWine (R-OH) and Rep. Ted Strickland (D-OH), the law authorizes a $50 million federal grant

program for states and counties to fund pre-trial jail diversion programs, cross-train police and mental health workers dealing with adult and juvenile offenders with mental health disorders, and expand prisoners' access to mental health treatment while incarcerated and upon re-entry into the community.

CONCLUSION

Growing evidence indicates that a lack of mental health care services leads to the incarceration of thousands of mentally ill youth each year. About 20 percent of youth in the juvenile justice system have a serious mental disorder. Experts in both the mental health and corrections systems believe many children with mental disorders would be better served in the community with a range of therapies and family supports. Such integrated systems of community-based care, however, have been slow to evolve across the United States.

A number of states and localities are leading the way in developing and funding community-based systems of care for children with serious mental disorders. In some instances, they are pooling agency monies to bolster services that ultimately are leading to lower use of inpatient care among children. In other instances, they are loosening Medicaid income standards and restructuring Medicaid's payment system to cover a range of nontraditional services (respite care, therapeutic summer camps, for example) that help children of all incomes stay out of institutions.

These pioneering efforts reveal the substantial challenges involved in reforming the U.S. mental health service system for children—the difficulties of infusing money into this system, redefining bureaucratic practices, redirecting dollars from institutional to community-based care, and educating the public about how untreated mental illness affects behavior. Monitoring the results of the model strategies discussed here should help policymakers institute more wide-scale change.

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