A Prescription for Crime Prevention:

Improving Youth Access to Effective Mental Health Approaches

A Working Paper by
Fight Crime: Invest in Kids *California*
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The knowledge and experience shared by the many mental health providers, experts, advocates and law enforcement leaders we spoke to were extremely valuable in helping shape this report. The list of the many people we interviewed, sometimes multiple times, is in Appendix C.

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FIGHT CRIME: INVEST IN KIDS *California* is a non-profit, non-partisan, anti-crime organization led by California's sheriffs, police chiefs, district attorneys and crime victims dedicated to reducing crime by promoting public investments in programs proven to keep kids from becoming involved in crime.

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Executive Summary

Quality mental health treatment is essential to prevent many youth with mental health problems from acting out, committing crime, and becoming involved in the juvenile justice system. Although not all youth with untreated mental health problems become criminals, they are at greater risk of antisocial and criminal behavior. Unfortunately, critical gaps in the youth mental health delivery system and inadequate funding of effective mental health programs limit youth access to needed mental health services, and in so doing, jeopardize public safety.

This paper examines youth mental health issues in California with an emphasis on the needs of kids at risk of getting in trouble as well as youth already involved in the juvenile justice system. The paper looks back at what early interventions might have helped steer troubled kids down a healthier path and also examines what the youth mental health and juvenile justice systems can still do to help turn around the lives of troubled kids and prevent them from committing future crimes.

Fortunately, the proof is in: a variety of innovative evidence-based programs work to improve youth mental health and reduce crime. The challenge is refocusing our priorities on increasing youth access to these effective programs and expanding them successfully. The paper recommends 11 youth mental health programs that we categorize as either "proven" or "promising" based on the strength of the research evidence demonstrating each program's impact on crime.

The paper also presents state policy recommendations and an action plan aimed at identifying the best policy opportunities and activating law enforcement leaders statewide as a strong advocacy voice for increasing youth access to quality mental health services. Law enforcement leaders know that both the mental health of youth and the public safety of our communities are at stake.

Chapter 1: Troubled Kids Mean Troubled Communities

Mental health is inexorably linked to the safety of our communities. Research shows that youth with untreated mental health needs are more likely to get in trouble and jeopardize public safety. Our juvenile justice institutions are filled with young people who have mental health problems that very likely contributed to their delinquent or violent behavior. Increasing access to mental health services, particularly for youth at risk of getting in trouble and juvenile offenders at risk of re-offending, is vital to preventing crime.

Chapter 2: Law Enforcement Leaders Speak Out

Law enforcement leaders, armed with the evidence and their first-hand experience, can send a strong message that increasing youth access to quality mental health services prevents crime and makes our communities safer. Because law enforcement officials arrest, prosecute, and, in many cases, lock up youth with mental health problems, they know that kids with unaddressed mental health needs may act out, commit crime, and ultimately end up in the juvenile justice system.

In January of 2002, FIGHT CRIME: INVEST IN KIDS *California* conducted a survey of its law enforcement members about youth mental health needs and services in their communities. Law enforcement leaders report significant contact with youth with mental health problems. They report that there are insufficient youth mental health services in their communities and in the juvenile justice system, and believe that early identification and intervention for youth with mental health needs

should be more of a public priority.

In recent years, law enforcement leaders have joined advocacy efforts to increase resources for adult mental health programs. With additional information and activation, law enforcement leaders can also add a valuable, unique voice to statewide advocacy efforts to increase youth access to quality mental health services.

Chapter 3: Expenditures Fail to Meet the Need

Although California spends nearly $1 billion annually on the public youth mental health system, more children are neglected by the system than are served. An estimated 20 percent of youth with mental health problems, including 50 percent of foster kids in need, fail to receive adequate mental health treatment. Youth with both mental health and substance abuse problems, racial and ethnic minority youth, and youth in the juvenile justice system also have significant unmet mental health needs.

Chapter 4: Gaps in the System

Critical gaps in the system hinder access to many of the services youth need most. Young kids, kids in foster care, and at-risk and troubled youth face the following barriers to access to effective mental health treatment in the community:

- Insufficient focus on prevention and early intervention
- Fragmentation and lack of multi-agency coordination
- Lack of home-based interventions
- Scarcity of high-end residential placements
- Lack of cultural competency within youth mental health programs
- Low utilization rates of Medi-Cal and Healthy Families services
- Shortages of mental health professionals

Although the mission of the juvenile justice system is to rehabilitate juvenile offenders, it is ill-equipped to provide adequate mental health services for all juvenile offenders in need. Many juvenile offenders not only failed to receive the mental health services they needed earlier in life, but continue to recycle through the juvenile justice system without adequate attention paid to their mental health needs. Youth with mental health problems face the following barriers to access to mental health care in the juvenile justice system:

- Lack of assessment, screening and early intervention
- Inadequate treatment services
- Lack of coordination with the mental health system
- Staffing shortages
- Lack of Medi-Cal reimbursement
- Few linkages with post-release programs

Chapter 5: Framework for Improvement

To close some of these gaps and broaden youth access to quality mental health services, the youth mental health and juvenile justice systems need to refine and retune their priorities. Specifically, youth with mental health problems should have increased access to the following mental health programs and services:

- Multi-agency collaborative programs that maximize resources and expertise
- Child and family-centered services
- Child abuse prevention programs
- Early intervention programs at school
- Programs targeting at-risk youth
- Programs for youth in the juvenile justice system
- Post-release programs for juvenile offenders transitioning back into the community
- Culturally competent services

In addition, further evaluation of many promising programs is needed to clearly establish whether they reduce crime and are cost-effective over the long-term.

Chapter 6: Recommended Youth Mental Health Programs

To implement the proposed framework for improvement, we recommend 11 evidence-based youth mental health programs that prevent crime and save money by reducing criminal justice and other out-of-home placement costs.

These "proven" or "promising" strategies fit into three phases of the continuum of care: (1) primary prevention; (2) early intervention; and (3) interventions for at-risk youth, youth in the juvenile justice system, and youth in post-release programs after involvement in the juvenile justice system. The quality youth mental health programs we recommend are:

- ✓ The Nurse Family Partnership {Proven}
- ✓ The Primary Intervention Program {Promising}
- ✓ School-Based Mental Health Centers {Promising}
- ✓ Multisystemic Therapy {Proven}
- ✓ Functional Family Therapy {Proven}
- ✓ Multidimensional Treatment Foster Care {Proven}
- ✓ Repeat Offender Prevention Program {Promising}
- ✓ Juvenile Mental Health Courts {Promising}
- ✓ Youth Development and Crime Prevention Initiative {Promising}
- ✓ Children's System of Care {Promising}
- ✓ Wraparound {Promising}

Chapter 7: California Policy Recommendations and Action Plan

To better serve the mental health needs of youth in California and save taxpayer dollars, these recommended programs should be expanded in California. The paper examines a variety of potential funding sources for program expansion. We also outline an action plan that would convene a task force of prominent mental health experts, law enforcement leaders and representatives of other stakeholder groups to identify the best policy opportunities and craft an advocacy campaign to increase resources for effective youth mental health programs. A critical element of the campaign would be to harness the influential voices of law enforcement leaders and activate them to become powerful advocates of the message that increasing youth access to quality mental health services is an effective crime-fighting strategy.

The alternative to improving our youth mental health delivery system is painfully obvious. We can

pay now by increasing resources for effective youth mental health programs, or we can pay later in increased crime and other social costs. Since there is a wealth of evidence that many youth mental health programs work to reduce crime, refocusing our priorities on expanding youth access to these programs is a necessary step towards making our communities safer.

Chapter 1: Troubled Kids Mean Troubled Communities

Mental health is inexorably linked to the safety of our communities. Research shows that youth with untreated mental health needs are more likely to get in trouble and jeopardize public safety. Our juvenile justice institutions are filled with young people who have mental health problems that very likely contributed to their delinquent or violent behavior. Increasing access to mental health services, particularly for youth at risk of getting in trouble and juvenile offenders at risk of re-offending, is vital to preventing crime.

The Need for Youth Mental Health Services

The number of kids and youth in need of mental health services is staggering. The Little Hoover Commission estimated that as many as three million California kids, 20 percent of the state's youth population, will experience a mental health disorder this year. Between five and nine percent of California kids have a serious emotional disturbance with extreme functional impairment.[1]

As many as 70,000, or 70 percent, of foster kids in California will experience mental health problems associated with the circumstances related to their removal from home or their foster care placement.[2] According to the California Institute for Mental Health, foster care kids are three times more likely to have serious emotional, behavioral or developmental problems than other kids in the community.[3]

The percentage of youth with mental health problems in the juvenile justice system is extremely high. Stanford University's recent assessment of the mental health needs of juvenile offenders in the California Youth Authority (CYA) found that 97 percent of its wards have mental health problems.[4]

The prevalence of mental health problems of youth entering juvenile halls run by county probation departments is also significant. In 2000, a Los Angeles Department of Mental Health and Los Angeles Probation Department joint pilot project screened all youth entering juvenile hall for a two-week period and found that 34 percent of all juveniles screened needed mental health services, and more than two-thirds of those youth exhibited evidence of sufficiently severe mental health problems to warrant intensive services.[5] Similarly, of 1,700 juveniles screened upon admittance to Santa Clara County juvenile halls in 2001, 37 percent had experienced severe traumatic experiences, 29 percent were significantly depressed, 10 percent had given up hope for their life, nine percent had symptoms of psychosis, and eight percent reported having considered suicide.[6]

IF A MENTAL HEALTH ISSUE IS CAUSING THE UNACCEPTABLE OR CRIMINAL BEHAVIOR, MERELY TREATING OR IMPOSING PUNISHMENT WON'T ADDRESS THE ROOT PROBLEM.

-- Sheriff-Coroner Virginia Black, Yuba County

Many youth suffer from other disorders in addition to their mental health problems. The most prevalent co-occurring disorders among youth with mental health needs are alcohol and drug abuse problems. Nationally, at least one-third of individuals with a mental health disorder also have a substance abuse problem.[7] The rates of co-occurring disorders are highest for the 15 to 24 age group.[8] Research suggests that many kids develop a substance abuse problem as a means to self-

medicate for their mental health disorder.[9]

At least half of the youth with mental health problems in the juvenile justice system also have a substance abuse problem.[10] In addition to finding that nearly all youth in the CYA have one mental health problem or another, Stanford University found that 85 percent of wards had substance abuse problems.[11] According to the study of youth entering juvenile hall in Los Angeles in 2000, more than half of the youth needing mental health services also had substance abuse problems.[12]

The Link Between Mental Health and Crime

While most youth with mental illnesses do not become criminals, many kinds of mental health problems do substantially increase the risk of crime. Research shows that a number of mental health problems, if left untreated, can lead to antisocial behavior, conduct disorders, substance abuse, and ultimately violence.

For example, poor emotional development can affect a child's ability to learn and engage with peers and eventually lead to antisocial behavior. Biologically-based mental health disorders such as Attention-Deficit/Hyperactivity Disorder (ADHD) and bipolar disorder have also been found in many cases to lead to conduct disorders and antisocial behavior in childhood.[13] In addition, poor parenting, child abuse or other family traumas can lead to depression, Post-Traumatic Stress Disorder (PTSD), and conduct disorders in youth.[14]

Kids with conduct disorders are more likely to struggle academically, drop out of school, exhibit anti-social behavior, and engage in substance abuse, all of which are risk factors for crime.[15] In fact, 75 percent of children with serious emotional or behavioral disorders never graduate from high school.[16]

Several academic studies and research projects illustrate the link between crime and various types of mental illness and its underlying causes. Researchers comparing kids who had suffered the trauma of child abuse and neglect to a control group of similar kids with no official record of being abused or neglected found that being abused or neglected in fact almost doubles the odds that a child will commit a crime as a juvenile.[19] A Sacramento County, California, study showed that children between the ages of nine and twelve who had been reported abused and neglected were 67 times

Mental Health Problems in Children and Youth

This paper uses the terms "mental health problems" and "mental health needs" very broadly to cover not only diagnosable mental health disorders but also the early signs of mental health problems in young children that may not yet rise to the level of a formal diagnosis. According to the U.S. Surgeon General, youth mental health can be adversely affected by a number of factors, including biological factors such as brain development and genetic predisposition to mental illness, environmental traumas such as child abuse, or psychosocial influences such as socioeconomic status, cultural background, and social supports to bolster resiliency.[17] Mental health problems in young children are generally recognized when a child does not meet developmental milestones. If the child's mental health needs are not addressed, the symptoms and consequences may become more severe with age and lead to a diagnosis of one or more mental disorders. The most common youth mental health problems include: (1) anxiety disorders; (2) conduct disorders; (3) Attention Deficit/Hyperactivity Disorders (ADHD); (4) mood disorders such as depression; (5) eating disorders; (6) developmental disorders such as autism; and (7) schizophrenia. Children with more severe mental health problems may be categorized under state and federal law as having Severe Emotional Disturbance (SED) and become eligible for certain treatment benefits.[18]

more likely to be arrested than other children in that age group.[20] Six percent of those reported abused or neglected had already been arrested by age twelve, compared to less than one tenth of one percent of other children in that age group.[21]

Research also shows that kids with ADHD, particularly those with associated conduct disorders, are at higher risk of developing learning disabilities, dropping out of school, exhibiting aggression, and committing crime.[22] In addition, a 2000 study of young adults in New Zealand, found that youth with personality disorders are 20 percent more likely to commit violence than youth without the disorders.[23] A number of studies have shown that the greatest risk of violence exists when mental illness is coupled with a co-occurring substance abuse disorder.[24]

Of course, given proper treatment early, young kids with mental health problems can succeed in school, develop positive social relationships, and stay out of trouble. However, as the research demonstrates, youth with untreated or inadequately treated mental health problems are at greater risk of engaging in antisocial behavior and eventually crossing the line to committing crime and violence.

Chapter 2: Law Enforcement Leaders Speak Out

Law enforcement leaders are keenly aware that access to quality youth mental health programs in their communities strongly influences public safety. Because law enforcement officials arrest, prosecute, and, in many cases, lock up youth with mental health problems, they have observed the relationship of mental illness to crime and know that too many kids with unserved mental health needs act out, commit crime, and ultimately end up in the juvenile justice system. They also recognize that there are insufficient mental health treatment services in their communities, and that many youth in the juvenile justice system with serious mental health needs never received the early intervention and treatment that might have helped steer them down a healthier path. Law enforcement leaders, armed with evidence and their first-hand experience, can send a strong message that increasing youth access to quality mental health programs can help prevent crime and make our communities safer.

Fight Crime: Invest in Kids *California* Survey of its Law Enforcement Members

In January of 2002, Fight Crime: Invest in Kids *California* conducted a survey of its law enforcement members about youth mental health issues and services in their communities. We asked these law enforcement leaders their views about (1) whether there is a link between mental illness and crime; (2) the gaps in mental health services in their communities; (3) whether they see youth with mental health problems in the juvenile justice system; (4) which youth mental health programs are effective in preventing or treating mental illness and reducing crime; and (5) which youth mental health programs are needed in their communities.[25]

The survey responses reveal that law enforcement leaders have significant contact with mentally ill youth and believe that there are insufficient youth mental health services in their communities:

- 67 percent of the law enforcement leaders surveyed believe there is a link between youth mental illness and crime;
- 85 percent say they see youth with mental health problems entering the juvenile justice system;
- 76 percent report that there are not enough youth mental health treatment services in their communities;
- 76 percent say that there are insufficient mental health treatment services for youth with mental health problems in the juvenile justice system; and
- 85 percent say that youth transitioning out of the juvenile justice system back into the community do not receive adequate mental health treatment.

The survey highlights how strongly law enforcement believes in the effectiveness of the following programs in preventing mental illness in youth and reducing crime:

- Child abuse prevention programs (86%);
- Early intervention for kids struggling at school or demonstrating anti-social behavior (91%);
- Mental health services in schools (66%);
- Substance abuse programs for youth and families (78%);
- Intensive interventions for high-risk first time juvenile offenders (89%); and

- Mental health services in the juvenile justice system (78%).

The vast majority of law enforcement respondents say their communities need more of the effective youth mental health programs and services listed above.

More than 70 percent of the law enforcement leaders surveyed believe that stronger collaboration between law enforcement, schools, child welfare agencies, and county mental health programs would help kids with mental health problems.

Finally, a resounding 86 percent believe that early identification and intervention for kids with mental health problems should be more of a public priority.

Recent Law Enforcement Advocacy on Mental Health Issues

With so many law enforcement leaders aware of the youth mental health treatment needs in their communities, an activated law enforcement community could be a powerful voice for improving the accessibility and delivery of quality mental health programs to kids and youth in need. Law enforcement has experience advocating for improvements to the mental health delivery system, although mainly with regard to adult mental health needs. Their interest and involvement in adult mental health issues lays a strong foundation for future involvement with youth mental health issues.

Adult mental health issues have long been of concern to law enforcement because so many adult offenders are mentally ill. It has been estimated that 30,000 California inmates are seriously mentally ill and that the cost of their processing, incarceration and treatment is between $1.2 and Juvenile offenders who have committed serious offenses may be sent to the California Youth Authority, a locked facility run by the California Department of Corrections. Currently, there are roughly 6,300 youth (wards) locked up in the California Youth Authority, at an annual cost of $41,000.[29]

$1.8 billion annually.[30] In Los Angeles County alone, 200 Department of Mental Health employees work full-time in the main county jail where over 2,000 inmates receive mental health treatment each day. The Los Angeles county jail has been called “the nation’s largest mental health treatment center.”[31]

Youth Involved in the Juvenile Justice System

Each year more than 200,000 juveniles are arrested, which is nearly 20 percent of the total arrests in California.[26] Like adults, youth can be charged with felonies, misdemeanors or infractions (known as status offenses, such as truancy), but are handled by the juvenile justice system’s distinct courts, detention facilities, laws and regulations. In California, the juvenile justice system is primarily a local responsibility. Once arrested, youth are detained in county juvenile halls run by county probation departments. Juvenile offenders who have committed lower level offenses remain the responsibility of county probation departments and may be sent to county ranches, camps, group homes, community diversion programs or their own home to serve out their sentences. Each youth on probation is assigned a probation officer who is responsible for monitoring the youth’s adherence to the terms of his or her probation and referring the youth to needed mental health, health, educational, or employment services. The average daily population of county juvenile halls, group homes, camps and ranches in California is 11,500 youth.[27] When added to the number of youth at home on probation or in community programs, there are close to 100,000 California youth on probation every year.[28]

Law enforcement has recently advocated for increased funding for services for mentally ill adults at risk of incarceration, in custody, and recently released from jail. For example, in 1998 the California State Sheriffs' Association cosponsored legislation with the Mental Health Association of California establishing the Mentally Ill Offender Crime Reduction Grant Program. This program has provided over $100 million in grants to demonstration projects designed to curb recidivism among adults with mental illness.

In 1999, the California State Sheriffs' Association, over 30 individual county sheriff departments, and several police departments supported legislation that established county demonstration projects providing comprehensive mental health services to seriously mentally ill adults who are released from jail, homeless, or otherwise at risk of incarceration or homelessness.[32] The bill analysis circulated prior to the Senate floor vote in favor of the bill quoted the California State Sheriffs' Association's statement of support: "[F]rom a law enforcement perspective, the need of adult mental health and related services is clear. The unfortunate reality is that our local jails have become the last resort for many of our mentally ill. This is a disservice to them and to us."[33]

Law enforcement has also been active in mental health policy locally. When San Diego County Sheriff Bill Kolender, a FIGHT CRIME: INVEST IN KIDS *California* Executive Committee member, became Sheriff, health services in San Diego County's jails were fragmented. The county mental health agency administered mental health treatment in the jails while the sheriff's department ran the general health practice. At Sheriff Kolender's urging, the county board of supervisors agreed to have the Sheriff's Department administer integrated health services, in effect giving the Sheriff's Department control over the county mental health agency's $4.5 million mental health budget for inmates. In addition, the Sheriff added his own Department's funds to increase the number of doctors and the number of hours worked by doctors to address inmates' various health and mental health needs. The Sheriff also added his own Department's funds to provide psychiatric social workers at all seven county jails, where previously no psychiatric social workers had been employed.[34]

THE FOCUS SHOULD BE ON PREVENTION, NOT INTERVENTION OR PUNISHMENT. EARLY EDUCATION AND TREATMENT ARE IMPERATIVE IN THE DEVELOPMENT OF OUR YOUNG CHILDREN.

-- Patricia Abadesco, Intervention Counselor, Union City Police Department

Sheriff Kolender also secured a state Mentally Ill Offenders Crime Reduction grant to support active case management in implementing discharge plans for mentally ill adult offenders. The discharge plans require collaboration among families, community-based organizations, and probation to provide mentally ill adult offenders psychiatric treatment, as well as career and academic assistance, upon their release. The four-year, $5 million grant funds an evaluation that is already showing the effectiveness of these efforts: three years after being released, inmates getting these services stay in treatment longer, are 30 percent less likely than other inmates to reoffend, and their repeat offenses are less serious.[35]

Los Angeles County Sheriff Lee Baca, also an Executive Committee member of FIGHT CRIME: INVEST IN KIDS *California*, has lobbied the Los Angeles City Council, County Board of Supervisors, and the

State for funding to establish a “Homeless Public Safety Center” that would provide mental health and other services for the homeless. His office is working closely with community organizations and the business community on this project. Last year, Sheriff Baca persuaded the legislature to provide “seed” funding for the project.[36]

Law enforcement support for policies addressing adult mental health has already begun to extend to juvenile mental health issues. Last year, the California Police Chiefs Association, California Peace Officers Association, California District Attorneys Association, and the California Chief Probation Officers Association all supported legislation that addressed both adult and juvenile mental health issues.[37] The bill created a Council on Mentally Ill Offenders to investigate and promote cost-effective approaches to meeting the long-term needs of mentally ill adults and juveniles who are, or are likely to become, offenders. The bill was signed into law and took effect in January 2002.[38]

Law enforcement, having worked extensively on increasing adult mental health resources and also keenly aware of their communities’ need for more youth mental health programs, has the potential to send a strong message to policymakers that any effective crime prevention strategy must include improving youth access to quality mental health treatment.

Chapter 3: Expenditures Fail to Meet the Need

California Spending on Youth Mental Health

California spends roughly $1 billion on mental health services provided to kids through public mental health programs.[39] This figure includes the primary sources of annual funding for youth mental health services in California: approximately $440 million through Medi-Cal; $47 million through the Individuals with Disabilities Education Act (IDEA), which provides special education services for kids with disabilities, including emotional disturbances; and $41 million for services through California's multi-agency Systems of Care programs.[40] California ranks 24th among the 50 states in per capita mental health expenditures by state agencies.[41]

In addition to funds allocated through the state's public mental health system, some kids receive mental health services through private insurance or other public service systems and funding streams,[42] including child care, the child welfare system, schools, primary care physicians, foster care placements, probation departments, and CalWORKs workforce development programs.[43]

Those Left Out

The services provided fall far short of meeting the need. According to the Little Hoover Commission, "more children are turned away from the public mental health system than are served."[44] An estimated 600,000 California kids, or 20 percent of the kids in need, fail to receive adequate mental health services.[45]

More than 50,000 kids in the foster care system, many of whom have suffered from child abuse, neglect, or other traumatic experiences, do not receive the mental health services they require.[46] Mental health services for these children are essential to boost the chances for family reunification or adoption. The California Institute for Mental Health reports that foster children with developmental disabilities and emotional problems leading to disruptive behavior have the hardest time exiting foster care and rejoining their families or being adopted.[47]

Youth with serious mental health and substance abuse problems who exhibit anti-social behavior frequently have difficulty obtaining treatment in the community, and often end up in jail instead of in treatment. Some mental health providers are unwilling or unable to work with youth who have multiple diagnoses because they are frequently difficult to serve. [48]

Broad ethnic and racial disparities exist between the numbers of kids who need care as compared to those who receive it. A recent report by the U.S. Surgeon General concluded that "racial and ethnic minorities have less access to mental health services than do whites."[49] Latino and African-American youth are the least likely of all groups to access mental health care.[50] Not only are racial and ethnic minorities less likely to seek and receive needed mental health care, but the care they do receive is more likely to be of low quality. The combined tragic effect of less access and poorer quality of care is that minority youth and families have a higher proportion of unmet mental health needs.[51]

Although the need for mental health services in the juvenile justice system is well documented, there are no hard estimates of how many mentally ill juvenile offenders receive adequate mental health care in California's juvenile justice system. Stanford's recent assessment of mental health care in the California Youth Authority found that the shortage of mental health staff within the CYA is unable to adequately meet the substantial mental health needs of its juvenile offender population.[52] By not adequately treating youthful offenders' mental health needs, which may have contributed to their criminal behavior, California's juvenile justice system is failing to achieve its goals of offender rehabilitation and public safety.

Chapter 4: Gaps in the System

While quality youth mental health programs can help steer kids down a healthy, functional path, numerous gaps in the public mental health and juvenile justice systems hinder access to many of the services that youth with mental health problems need most. This chapter examines some of the systemic barriers preventing young children, at-risk and troubled youth, youth in the juvenile justice system, and youth transitioning from the juvenile justice system back into the community from accessing the mental health services they need.

Barriers Faced by Young Kids, Kids in Foster Care and At-Risk and Troubled Youth

Some of the critical barriers preventing young kids, kids in foster care, and at-risk and troubled youth from receiving adequate mental health services in the community include:

Insufficient Focus on Prevention and Early Intervention: Most of California's public mental health spending is rationed to the most severely mentally ill youth. There are too few prevention programs for young kids and an insufficient number of low or medium-intensity intervention services available for kids starting to show signs of mental health problems. In addition, there is a lack of transitional programs for children ready to move from intensive services to lower levels of care.[53] Although there are mental health services in some schools, few school programs have the resources needed to identify the early signs of mental health problems and intervene effectively.[54]

Prevention and early intervention programs are a lower priority in part because there is little incentive for counties to spend a little more now, in start up costs for new programs, to save more in the future. The resources, leadership, and collective will needed to implement new programs, train staff, and reallocate resources away from existing programs to new ones are significant barriers to creating more front-end programs.

Fragmentation and Lack of Coordination: Many youth in need of mental health services fall through the cracks of California's mental health system because it is fraught with fragmentation, inefficiency and a widespread lack of coordination. Mental health, juvenile justice, health, education, social services, and child welfare agencies all provide some mental health services, yet have separate eligibility rules, funding streams and administration. Often there is confusion about which of the multiple systems is responsible for providing services and whose resources should pay for them. A young person who has contact with multiple systems at one time may have school administrators, foster parents, social services staff, probation officers, and primary care providers responsible for providing services, yet no one individual in charge of coordinating all of the levels of care needed. The Little Hoover Commission described California's mental health system as a "crazy quilt of entitlement, categorical and pilot programs" which provides "little or no continuity of care" for youth in their various stages of need.[55]

For example, many foster youth are unable to access needed mental health services due to inadequate collaboration among child welfare and mental health providers. Mental health staff are often

unfamiliar with the intricacies of the child welfare system, are unaware of the judicial timeframes for services, and have a difficult time coordinating treatment with foster and biological parents. The child welfare system may change a foster child's placement without notifying mental health staff. When families are reunified, they are sometimes cut off from mental health services at a time when they critically need support services to help improve family functioning.[56]

> **The gap in services is in the area of kids and teens who aren't yet in the mental health or juvenile probation system. Many kids aren't diagnosed early enough.**
>
> *-- Detective Hollis Tong, Youth Services Bureau, Concord Police Department*

In addition, youth with both mental health and substance abuse problems are often juggled among different providers who may treat only one disorder but not the other. A 1996 survey of California county administrators of mental health and substance abuse programs found that fewer than half of all counties had integrated or jointly funded programs.[57] As a result, individuals with both mental health and substance abuse problems often fail to receive adequate treatment for their dual and often related needs.[58]

One of the weakest links in the mental health system is limited coordination between mental health providers and the juvenile justice system, which will be discussed later in this chapter.

Lack of Home-Based Interventions: There is a lack of intervention services designed to keep youth with mental health problems at home rather than institutionalizing them in residential treatment facilities. Youth who could benefit from home-based treatment but instead end up in residential facilities may suffer from the trauma of being away from their family, have difficulty reentering the family, and fail to learn behaviors needed in the community. They may also pick up anti-social behaviors from other disturbed children housed in the facility.[59]

Scarcity of High-Intensity Residential Facilities: The cost and scarcity of residential treatment facilities in many counties preclude many youth from receiving the high level of care they need. Many are sent to juvenile justice facilities instead. According to Larry Dodson of the Los Angeles Probation Department, "Many kids end up in juvenile hall because of a lack of [mental health] placements that will take them."[60] The high cost of acute mental health treatment facilities even leads some counties to send juvenile offenders with serious mental health needs to be locked up by the California Youth Authority even though the juveniles have committed non-violent offenses.[61]

Lack of Cultural Competency: Treatment programs lacking in cultural competence pose an additional barrier for racial and ethnic minorities. According to the U.S. Surgeon General, many ethnic and racial minority families are deterred from obtaining appropriate mental health care due to language barriers as well as poorly trained clinicians who may be unaware of the client's culturally different needs, the stigma they attach to mental health treatment, and the client's potential fear and mistrust of the medical profession.[62]

Low Utilization Rates: Underutilization of the mental health services provided by Medi-Cal and Healthy Families also plays a role in kids not receiving the mental health treatment they need and for which they may be eligible. Many families are unaware that Medi-Cal and Healthy Families cover

youth mental health services. Other families may seek mental health treatment, but are often either unable to obtain the necessary referrals or find county services and providers overloaded.[63] Currently there are no data on the number of kids in Healthy Families who are getting basic mental health services through managed health care plans. However, Healthy Families kids who are seriously emotionally disturbed (SED) are supposed to be referred by managed health care plans to the county for mental health services. According to the Managed Risk Medical Insurance Board, however, only one-half of one percent of all kids in the Healthy Families program have been referred to the county for mental health treatment.[64]

Staffing Shortages: There are not enough early childhood mental health specialists and child psychiatrists in the state public health system. In California, the vacancy rate for mental health professional public positions is about 30 percent. With high turnover in county mental health departments and a trickle of students graduating with degrees specializing in childhood mental health, many counties are simply unable to fill their mental health positions.[65]

Barriers to Treatment in the Juvenile Justice System

Many youth who fail to receive adequate mental health care earlier in their lives ultimately wind up in the juvenile justice system. The juvenile justice system's mission is to rehabilitate youth so that they are less likely to re-offend once they transition back into the community, and mental health care is an important element of rehabilitation. Unfortunately, California's juvenile justice system itself contains significant obstacles to mental health treatment for the thousands of youthful offenders with mental health needs.

> I HAVE HAD FREQUENT CONTACT WITH JUVENILES WHO OBVIOUSLY HAVE MENTAL HEALTH PROBLEMS THAT HAVE NEVER BEEN ADDRESSED. THEY ARE ARRESTED FREQUENTLY BUT THEIR PROBLEMS ARE NEVER RECOGNIZED.
>
> *-- Shannon Adams, Training Officer, Fresno Police Department*

Lack of Assessment, Screening and Early Intervention: In most juvenile justice institutions, a lack of staff and resources make it nearly impossible to screen and provide a comprehensive mental health assessment of every youth entering juvenile hall. Stanford University's recent evaluation of the California Youth Authority's mental health delivery system reported that screening and referral within the CYA was "extremely uneven." Similarly, evaluators of Santa Clara County's intake processes in juvenile hall found that the county juvenile justice system failed to adequately identify and later treat juveniles with mental illness.[66]

Inadequate Treatment Services: The juvenile justice system fails to address the mental health problems of all youthful offenders in need. Stanford researchers found that the CYA focuses most of its mental health resources on the wards with extreme mental illness, while other wards, almost all of whom suffer from mental health problems, sit on waiting lists to receive mental health services.[67]

Similarly, many probation departments focus most of their treatment resources on the juvenile offenders with the most severe mental health needs. For example, researchers who took a hard look at Orange County's probation system before the county developed intensive youth programs for

potential repeat offenders found that probation youth often failed to receive adequate attention to their mental health and other needs "until after they established a record of serious repeat offending." [68]

Lack of Coordination with the Mental Health System: Although juvenile offenders with serious mental health needs permeate the juvenile justice system, many juvenile justice facilities do not efficiently coordinate care with mental health professionals. The lack of effective collaboration between the California Youth Authority (CYA) and the California Department of Mental Health greatly impairs the effective delivery of services within the CYA.[69] In addition, mental health records from schools or outside mental health providers often are not forwarded in a timely fashion to county probation departments, causing many mentally disturbed youth to undergo lapses in treatment and medication.[70]

Staffing Shortages: Shortages of mental health staff within the juvenile justice system make it nearly impossible to provide juvenile offenders with proper mental health care. According to Stanford University researchers, psychiatrists trained in child psychiatry and psycho-pharmacology are a "rarity" inside the CYA. Only eight of the CYA's 33 mental health programs are fully staffed. In particular, mental health services for the general ward population are "thinly staffed." Because of the staffing shortage, mental health clinicians operate in a "crisis mentality," racing from one emergency to another, without the time or resources to provide juvenile offenders with adequate care. Stanford recommends that, at a minimum, the CYA add 186 mental health clinicians to provide adequate services.[71]

> **THE LACK OF FUNDING MEANS THAT ONCE YOUTHS LEAVE THE JUVENILE JUSTICE SYSTEM, THAT TREATMENT STOPS.**
>
> *-- Officer Toni Caylor, Arcadia Police Department*

Staffing shortages of mental health professionals also plague most county juvenile halls. For example, the 2000 evaluation of juvenile halls in Los Angeles County found that "current levels of staffing within the halls is inadequate to respond to the [mental health] needs identified." [72]

Lack of Medi-Cal Reimbursement: One fiscal challenge to serving the mental health needs of juvenile offenders is that federal rules do not allow Medi-Cal reimbursement for most health services provided in the CYA and in juvenile halls run by county probation departments. Federal Medicaid rules specifically exclude coverage for inmates of juvenile justice institutions, unless a youth has been placed there for reasons other than criminal activities (such as by child protective services for the youth's own protection), they are being detained in the institution temporarily (such as those awaiting adjudication), or they are placed in a secure facility that is not part of the juvenile justice system (such as some group homes for lower-level offenders).[73] The inability of the juvenile justice system to access Medi-Cal funding for mental health services is an ongoing financial barrier to providing comprehensive mental health services to juvenile offenders.

Few Linkages with Post-Release Programs: The juvenile justice system has a severe shortage of programs aimed at helping juvenile offenders access services once they reenter the community.[74] In addition, those juvenile offenders who lost their Medi-Cal eligibility once they entered a juvenile justice institution often must reapply and face a delay before eligibility restarts.[75] By not providing adequate post-release coordination with community mental health services, the juvenile justice

system increases the risk that youth will relapse, re-offend and recycle back into the juvenile justice system.

Chapter 5: Framework for Improvement

To start closing the gaps in youth mental health services and broaden youth access to needed mental health treatment, the youth mental health and juvenile justice systems need to refine and retune their priorities. Young people with mental health problems need a variety of effective mental health programs designed to serve youth at all stages of need, from prevention and early intervention programs to services for at-risk youth, youth involved in the juvenile justice system, and juvenile offenders in post-release programs.

Collaborative and Integrated Services: Youth with mental health problems, who often come into contact with multiple service delivery systems, need access to well-coordinated and integrated mental health services. This is not only in the best interest of the children and families, but may also save money by eliminating duplication of effort and by improving results. Effective collaborative approaches focus on the best interests and unique needs of the child and family, share resources and expertise, respect multiple perspectives and agency goals, and promote cross-agency dialogue and training. Strong leadership is required to overcome the various challenges to effective collaboration, including resistance to change, differing agency goals, staff expertise, and funding sources. Since multiple agencies provide services to youth with mental health problems and no one agency can solve the problems alone, improved coordination is critical.

> **Continued Communication and cooperation among agencies allows for better and more effective identification and treatment. It also allows for less duplication of services.**
>
> *-- Chief Stephen Lodge, Santa Clara Police Department*

Child and Family-Centered Services: Each child and family has a unique set of strengths and needs. Programs that identify and build on strengths, as well as tailor services to the individual needs of each youth and family, have a stronger probability of success over the long-term. Many successful child and family-centered mental health programs provide services to the youth and family in the home and community environment. Those that focus on improving family functioning at home can often help the youth avoid out-of-home placement.

Child Abuse Prevention Programs: Strong families are the key to healthy children. Child abuse prevention programs that help parents improve their coping skills and mental health benefit the emotional development and needs of kids. Research shows that children who are abused or neglected face a substantial risk of developing mental health disturbances, including depression, Post Traumatic Stress Disorder, and anti-social behavior. Preventing child abuse and neglect not only reduces the risk that children will be physically hurt and removed from their home, but also reduces the chances that children will develop mental health problems as they grow older.

Early Intervention at School: Responding to signs of mental health problems early makes it easier and less expensive to improve problem behaviors. Schools provide a key location for early identification and intervention in youth mental health problems. Educators trained to identify early signs of mental disturbances are valuable referral sources. School-based mental health programs are easily accessible to youth and save parents the time and transportation demands involved in obtaining mental health treatment from off-campus providers. Services provided by school counselors or

community partners on the school site can also be less intimidating and stigmatizing to the child than an unfamiliar doctor's or therapist's office. In addition, many school-based mental health centers successfully pool funding streams to cover services for uninsured children who may not be able to obtain mental health treatment elsewhere.

Programs that Target At-Risk Youth: There is a substantial need for mental health programs that target youth who are highest risk for mental health problems and delinquency. Kids who struggle at school, have weak family and community supports, have a history of acting out and of anti-social behavior, or have abused drugs or alcohol, are all at heightened risk of committing crime. Many of these youth may be in the foster care system or have experienced out-of-home placement in the past. Programs aimed at improving individual and family functioning, providing educational and employment assistance, reducing drug abuse, and teaching discipline and coping skills are critical strategies for helping guide at-risk youth down a promising path.

Interventions for Youth in the Juvenile Justice System: Mental health services aimed at meeting the mental health needs of juvenile offenders should be an integral part of the juvenile justice system. Every juvenile offender entering the juvenile justice system should be screened and assessed for mental health problems. All juvenile offenders in need should have access to quality mental health treatment services. In addition, the juvenile justice system should provide intensive services to first-time offenders with the highest risk of recidivism, including those who have experienced a mix of school failure, family dysfunction, a delinquent past, and drug use. By expanding treatment of juvenile offenders' mental health and other needs, the juvenile justice system can both improve youth mental health and reduce recidivism.

Post-Release Programs that Target Juvenile Offenders Transitioning Back into the Community: For youth who suffer from mental health problems, the end of incarceration rarely means that there is no longer a need for mental health treatment. The mental health needs that may have contributed to the youth's criminal behavior will still require attention to prevent further criminal activity. Effective post-release programs for juvenile offenders transitioning back into the community often include mental health and substance abuse counseling services, educational and job opportunities, housing assistance, and help reapplying for Medi-Cal and other public services.

Culturally-Competent Services: California's tremendous diversity requires improved cultural competence within the youth mental health system. Programs that hire, train and educate providers about the unique mental health needs of ethnic minority youth are essential. Special sensitivity to those needs can help youth overcome fears about obtaining treatment and communicate effectively with their mental health providers.

Additional Research to Demonstrate Program Effectiveness: Decades of research show that many youth mental health programs work to improve behavior and prevent crime. A number of youth mental health programs have consistently been proven to work over the long term, and with diverse youth populations. Other programs report positive results in the short-term but have not yet followed participants for long enough post-treatment to fully assess the long-term impact, or have not been tested through rigorous evaluations using control groups. Research demonstrating that program participants had long-term reductions in criminal activity as compared to control group youth can provide persuasive evidence to policymakers that expanding such programs are a cost-effective way to promote youth mental health and public safety. In addition, communities that have

made long strides towards improving collaboration need to be further studied to provide a blueprint for counties still in the early stages of integration. An expanded research base can help efforts to replicate successful youth mental health programs and bring them to scale.

Chapter 6: Recommended Youth Mental Health Programs

Based on the proposed framework for improvement and the clear need for increased access to quality youth mental health services, we recommend 11 evidence-based programs that work to prevent crime and improve youth mental health. The programs we recommend have several important ingredients in common. Each is backed up by evidence demonstrating its effectiveness at either preventing youth from getting in trouble or preventing youth already involved in the juvenile justice system from re-offending. In addition, as demonstrated by the FIGHT CRIME: INVEST IN KIDS *California* survey results, these are the kinds of programs that law enforcement leaders believe their communities need to keep youth out of trouble.[76] Each of the programs requires effective collaboration by multiple agencies and tailors services to the unique needs of the youth and family. Finally, these programs all help to meet the tremendous need for increased access to quality youth mental health services.

We categorize the recommended programs based on the type of program and which youth are targeted: (1) prevention; (2) early intervention; or (3) intervention for at-risk youth, youth involved in the juvenile justice system, and youth transitioning from the juvenile justice system back into the community.

We also identify programs as either "proven" or "promising." The standards for designating a program "proven" are quite high. We designate a program as "proven" if it satisfies three criteria. First, the program evaluation shows significant and sustained evidence of crime reduction. Second, the evidence is based on research designs that use random assignment of research participants to the program. Research using random assignment permits the most valid conclusions of program effectiveness because it allows a direct comparison of youth who participated in the program to similar youth who did not (i.e., control groups). Third, the research shows that positive results have been achieved in replications of the program at multiple sites. All of the "proven" programs here have met these criteria. Our criteria are the same as those used by the Center for the Study and Prevention of Violence at the University of Colorado when they designated these programs as "Blueprint" programs for violence prevention.

Programs are identified as "promising" if they have evidence of crime reduction, or other improved outcomes that may lead to crime reduction, but either were evaluated over too short a time to assure that results will be sustained over the long term, or employed research designs not involving random assignment. The non-experimental designs compared pre- and post-program outcomes for program participants only or compared program outcomes for participants to general expectations for similar non-participants. Further long-term evaluations using random assignment would be needed before these "promising" programs could be labeled as "proven" given the strict criteria used here.

Each program recommendation discusses the following elements:

- The key components of the program
- The program providers
- The collaborative partners
- Research evidence demonstrating that the program works to reduce crime
- Cost-effectiveness

- Implementation status in California
- How the program is funded
- The political landscape

All of the recommended programs are being implemented in California to varying degrees, although most of them currently serve very limited numbers of youth in need. We recommend that these programs be expanded to help meet California's significant unmet youth mental health needs.

Prevention

Nurse Family Partnership Program {Proven Program}

What is the Program?

The Nurse Family Partnership is a child abuse prevention and mental health treatment program in which specially trained public health nurses make regular home visits to low-income, first-time mothers. A goal of the program is to reduce the child's risk for anti-social behavior by improving both maternal and child health and reducing the risk of child abuse. The program was designed in the 1970s by David Olds, Ph.D., who first tested it in Elmira, New York, and then conducted later trials in Denver, Colorado and Memphis, Tennessee.

What are the Key Components of the Program?

Through the Nurse Family Partnership Program, each low-income, first-time mother in the program is assigned a public health nurse who visits the family during pregnancy and throughout the first two years of the child's life. The nurses help mothers promote the healthy emotional development of their baby, establish a positive relationship with their child, and build self-efficacy as an adult and parent. The nurses also screen mothers for depression and substance abuse, provide general health advice and referrals, and help women set educational goals and search for employment. The program also works with the fathers, if present. Visits lasting 60-90 minutes are scheduled every one to two weeks throughout most of the program, although visits can occur more frequently if crises appear. Each nurse carries a caseload of no more than 25 families and receives weekly supervision by nurse supervisors. The program has been successfully implemented in rural, urban, and various ethnic communities.

Who are the Providers?

The Nurse Family Partnership employs public health nurses with at least a bachelor's level of training. The program prefers nurses because of their clinical training in maternal and children's health.[77]

Who are the Collaborative Partners?

County public health, mental health and social service agencies work collaboratively to refer and provide services to the participating families.

Does it Work?

The Nurse Family Partnership Program is a "Blueprints proven"[78] program that successfully prevents the onset of a series of mental health, health, and social problems in both children and their

mothers. Rigorous long-term studies that compared home-visited families and control groups without services found that, fifteen years after the services ended, the program reduced child abuse by 80 percent, home-visited mothers had only one-third as many arrests, and home-visited children were only half as likely to be delinquent as similar children without services. The studies also found that women in the program spent less time on welfare, smoked fewer cigarettes, and consumed less alcohol than women in control groups.[79] The Nurse Family Partnership has shown consistently significant positive results when provided to families at greatest risk: low-income, unmarried women. Research has shown that the program produces fewer benefits for women of a higher socioeconomic status who are less at-risk.[80]

Other home visitation programs, which employ social workers or paraprofessionals instead of nurses, have also had some positive though less consistent results.[81] The Nurse Family Partnership, however, has shown consistent success in several long-term studies and is the only "Blueprint proven" home-visiting program.

Is it Cost-effective?

According to a RAND analysis, the program fully repaid its cost within the first three years, and ultimately saved over $4 for every $1 spent.[82] The cost of the program per family is about $2,500 to $3,000 per year, or $6,250 to $7,500 for the full two-and-a-half year program.[83] Therefore, for every family receiving the full benefits of the Nurse Family Partnership Program, taxpayer savings could be as high as $12,000 per year.

What is its Implementation Status in California?

In 1998, Fresno was the first county in California to implement the program. Today, the program serves about 1,300 families in 11 California counties: Bakersfield, Fresno, Los Angeles, Monterey, Orange, Riverside, Sacramento, Santa Clara, San Diego, San Luis Obispo, and Tulare.

How is it Funded?

Counties currently finance the program by cobbling together funding from a variety of sources, including Medi-Cal targeted case management funds, Proposition 10, CalWORKS, county general funds, tobacco litigation funds, and federal funds through Safe Schools/Healthy Students, Title V Maternal and Child Health Block Grants, and Family Preservation funding through Title IV-B of the Social Security Act.

What is the Political Landscape?

Currently there is no statewide advocacy push for the Nurse Family Partnership Program. However, Public/Private Ventures has begun working with the Nurse Family Partnership to plan an expansion and advocacy effort in California. At the county level, public health nurses who have learned about the program have been the main program advocates. There may be opportunities for administrative advocacy before the Department of Health Services to amend Medi-Cal regulations regarding reimbursement for home visitation services and also urge the State to pick up the "state share" of the Medi-Cal costs.[84] There are also opportunities for advocacy work at the state and county level to expand Proposition 10 and other county-level funding of the programs.

Early Intervention

Primary Intervention Program (PIP) {Promising Program}

What is the Program?

The Primary Intervention Program (PIP) is a school-based prevention and early intervention program aimed at enhancing the social and emotional development of young kids and preventing the development of serious mental health problems, substance abuse, academic failure, and delinquent behavior. The PIP program was modeled after the Primary Mental Health Project (PMHP), developed in 1957 by the Children's Institute in Rochester, New York.[85]

What are the Key Components of the Program?

PIP targets students in grades K-3 who have mild-to-moderate school adjustment problems and may also be at risk of out-of-home placement. The program identifies kids early through a systematic screening process. The program then refers targeted kids to "child aides" who help students overcome their acting out behavior, shyness, inattentiveness, and restlessness, all of which may interfere with learning. Child aides use non-directive play techniques with the child individually for 30-45 minutes per week in a specially equipped activity room on the school campus. Services are provided on a short-term basis, with students attending approximately 12 weekly sessions. Child aides typically have caseloads of 12-16 students. PIP does not provide treatment to kids with more serious mental health problems, but instead refers them to appropriate mental health providers.

> **I BELIEVE THERE IS A SERIOUS VOID IN MENTAL HEALTH SERVICES FOR ALL KIDS, ESPECIALLY IN THE YOUNGER GRADES.**
>
> *-- Chief Joseph Santoro, Monrovia Police Department*

Who are the Providers?

Child aides, who are paraprofessionals with limited mental health training, provide the direct services to the targeted students at the school-site. The child aides are supervised and trained by credentialed school psychologists, school social workers, or school counselors in collaboration with mental health professionals.

Who are the Collaborative Partners?

The program is provided collaboratively by schools, county departments of mental health, and community non-profit mental health agencies.

Does it Work?

In 1999, the U.S. Surgeon General featured PIP as one of five "exemplary" mental health programs for children.[86] A California Department of Mental Health statewide evaluation of the PIP programs found that kids in PIP significantly improved their cooperation, self-control, and social maturity. The evaluation found that, after treatment ended, program participants moved out of the "at-risk" category, and maintained improvement for at least two years after services.[87] In ratings completed by school psychologists, post-treatment results showed that 70 percent of PIP students improved academically, 74 percent improved their classroom behavior, and 62 percent improved their school discipline.[88] There have been no long-term evaluations of the PIP program to date that compare the outcome of kids in PIP to control group youth.

Is it Cost-effective?

There has been no rigorous analysis of the cost-savings of PIP. The California Department of Mental Health, however, asserts that PIP saves money by minimizing the need for more intensive and costly services as kids grow older.[89] Potential cost-benefits to schools of reduced anti-social behavior of students include reduced need for professional intervention, reduced staff time spent on discipline referrals and increased school funding due to improved Average Daily Attendance. The average cost of PIP per student is $500.

What is its Implementation Status in California?

PIP was first implemented in California in 1982 through AB 1639 (Bates). Currently there are PIP programs at 467 school sites in 32 California counties, serving about 22,500 students.

How is it Funded?

The programs currently receive $12 million in annual funding through California's Early Mental Health Initiative (EMHI).

Political Landscape

There is a substantial base of support for PIP. The program has historically attracted bi-partisan support, with Democrat Assemblyman Tom Bates authoring the initial legislation (AB 1639) and Republican Governor Pete Wilson expanding the program almost 10 years later. In 2000, when Assemblymember Aroner introduced AB 1980 to extend the PIP grants from 3 to 5 years, supporters included the California Teachers Association, California Probation Chiefs Association, American Federation of State, County and Municipal Employees (AFSCME), and the National Association of the Mentally Ill. However, while the legislation proceeded through the Legislature, Governor Davis vetoed a proposed $5 million increase to the program in 2000.[90] Without the needed funding increase, AB 1980 failed passage at the end of the 2000 legislative session. With the historically strong legislative support of PIP, targeted advocacy efforts at the legislative and executive level could lead to future program expansion.

School-based Mental Health Centers (SBMHCs) {Promising Program}

What is the Program?

School-based Mental Health Centers (SBMHCs), which deliver mental health services to school-age youth at school sites,[91] are a valuable means to identify youth mental health problems and intervene early. The SBMHCs provide youth with convenient access to mental health services, remove transportation barriers to obtaining services, and are offered in familiar settings that are less intimidating and stigmatizing to youth than a physician's or therapist's office. The SBMHC's are often part of a more comprehensive school-based health clinic.

What are the Key Components of the Program?

The SBMHCs offer students treatment or referrals for depression, anxiety, suicidal tendencies, emotional trauma caused by violence, substance abuse, domestic violence, child abuse, and other mental health problems. Both individual and group counseling services are provided, while kids with more serious mental health problems are often referred to other providers for more intensive services. Mental health personnel also train teachers to identify mental health problems early. Most SBMHCs operate on the school campus full-time during the week and often during weekends and

summer breaks. Students can request an appointment or be referred to the SBMHC by teachers or school staff. Parental consent is generally required for on-site mental health services.[92]

Who are the Providers?

School psychologists or local community providers, under contract with county mental health departments, generally provide the on-campus services, case management, and outside referrals for more serious mental health problems. In some SBMHCs, graduate student interns who are supervised by mental health staff provide part-time counseling assistance. The providers have frequent contact with counselors, teachers, principals, and other school personnel who refer students to the SBMHCs.

Who are the Collaborative Partners?

Schools, county mental health departments and local community mental health providers collaborate to provide the mental health services offered by SBMHCs. County mental health departments often play a pivotal role in helping SBMHCs obtain reimbursement from Medi-Cal or other state or federally subsidized insurance.

Does it Work?

Preliminary outcome data from the SBMHCs in the Pasadena School District indicates that students who received mental health services from the SBMHC had decreased aggression, threatening behavior and classroom disciplinary problems, and increased academic achievement. School suspensions, on-campus incidents of battery, weapons possession, and drug and alcohol use all dropped since the clinics opened in 1999.[93] At San Fernando High School, kids who received mental health services through the school-based clinic dropped out of school at half the rate of the general student population,[94] and fewer fights and gang-related incidents occurred on–campus after the clinic opened in 1987.[95] School-based health centers are viewed as effective at helping kids academically by reducing or even removing mental health problems, which are often strong impediments to learning.[96] Further evaluations with rigorous research designs involving control groups would be helpful in further demonstrating the effectiveness of SBMHCs.

Is it Cost-Effective?

To date, there have been no specific cost-savings analyses of SBMHCs. However, potential cost-benefits to schools include reduced staff time spent on disciplinary action, better attendance, and less money spent on more costly interventions.

What is its Implementation Status in California?

A model SBMHC program in California is in the Pasadena School District. In Pasadena, there are SBMHCs at 32 of the district's 33 schools. More than 2,000 students, almost 10 percent of the student population, have received mental health services from Pasadena's SBMHCs since they opened in 1999. There are also more than 100 school-based health centers in California, and about 70 percent of them provide mental health services.[97] San Fernando High School, for example, has been operating a school-based health center since 1987. The on-site health center provides mental health treatment in addition to other health services. About 40 percent of the students who visit the clinic seek mental health services.[98]

How is it Funded?

Most SBMHCs receive some Medi-Cal, Healthy Families or private insurance reimbursement for

eligible students. For those services and students not covered by insurance, SBMHCs have obtained additional funding through Child Health and Disability Prevention (CHDP) funds, Individuals with Disabilities Act (IDEA) funds, private foundations, county general funds, in-kind contributions from schools and community providers, and other local sources. Pasadena, for example, received $2 million in 1999-2000 from the Los Angeles County General Fund to fund services for uninsured students, although that funding source has not been renewed due to fiscal pressures. The district is currently attempting to find alternate funding sources.[99] San Fernando Valley High received initial funding for its school-based health center from the Robert Wood Johnson Foundation and continues to fund its services through insurance reimbursement, school district funding, and other local sources.[100] In addition, some school-based health centers received start-up funding through Healthy Start, but more than half of those initial Healthy Start grants have expired.[101]

What is the Political Landscape?

Those who have historically supported SBMHCs include mental health organizations and school personnel who benefit from reduced student behavioral problems at school. Recent legislative efforts to expand mental health services at schools, however, have not succeeded. Assembly Bill 2105 (Scott) and Assembly Bill 971 (Steinberg), introduced in 2000 and 2001, respectively, were supported by various mental health organizations and counties, but ultimately failed passage. The bills received some opposition by individuals concerned about the "overmedication" of kids.[102] More education about the protocols used by SBMHCs and the parental consent requirement may be required to allay fears about the overmedication issue.

Interventions for At-Risk Youth, Youth in the Juvenile Justice System, And Youth Transitioning From the Juvenile Justice System Back Into the Community

Multisystemic Therapy (MST) {Proven Program}

What is the Program?

Multisystemic Therapy (MST) is an intensive, family-based treatment model aimed at helping youth and their families understand the root causes of the youth's anti-social behavior and make the necessary personal and family improvements to bring about long-term positive behavior change. The program targets youth at risk of out-of-home placement because of behavior problems, juvenile offenders, and youth transitioning out of the juvenile justice system.

What are the Key Components of the Program?

MST uses techniques from cognitive, behavioral and family therapies. After assessing the youth's and family's risk factors and assets, the MST therapist works with the youth and family to improve the youth's behavior, coping skills, mental health, academic performance, and interaction with prosocial peers and positive community influences. MST therapists also work to improve parenting skills and help the family develop extended family and informal support networks. MST therapists have small caseloads of four to six families. They visit with each youth and family at home or in the community several times a week over a three to five month period, and are available 24 hours a day. Services are often provided on weekends, evenings and other times convenient for the family. MST programs have been implemented in many diverse communities by therapists who reflect the ethnic makeup of the families being served.

Who are the Providers?

MST is provided by therapists who are supervised by doctoral-level mental health professionals. MST, Inc., based in South Carolina, provides extensive training to the therapists and supervisors, and also includes collaborative members in portions of the training. MST, Inc. consultants provide support and advice to MST providers throughout the program's implementation.

Who are the Collaborative Partners?

MST can be collaboratively provided by County Departments of Mental Health, community mental health providers, MST, Inc., and County Departments of Probation.

Does it Work?

MST has been recognized as a "Blueprints proven" program.[103] Multiple evaluations from programs in other states found that, 59 weeks after treatment began, youth in the MST programs had a 20 percent lower rate of recidivism and spent an average of 10 fewer weeks in detention as compared to similar youth in the control group.[104] Youth in MST programs also had fewer mental health problems and more improvement in family functioning than control group youth.[105]

Is it Cost-effective?

Estimates of cost savings, based on the reduced need for incarceration and residential placement, range from $7,000 per youth to more than $24,000 per youth.[106] The average program cost is $4,500 per youth.

What is its Implementation Status in California?

Currently, the only MST site in California is in Los Angeles, through a collaboration of the Los Angeles Probation Department, the Los Angeles Department of Mental Health, and four community mental health providers. The Los Angeles MST project began in October 2001 and plans to serve 50 kids this year. The Los Angeles project targets 12-17 year-old youth who are at home on probation, are chronic offenders, and either demonstrate serious anti-social behavior or have substance abuse problems. The youth are all at risk of being removed from their homes and placed in institutional settings.

How is it Funded?

The Los Angeles MST project has received $306,000 in state Juvenile Justice Crime Prevention Act funds for planning, provider training, and coverage of some uninsured youth. Some MST services are billable to Medi-Cal, although the costs of training providers are not.[107]

What is the Political Landscape?

Although there has been no statewide push for MST program expansion, there is strong support for the program in the Los Angeles Probation Department, the California Chief Probation Officers Association and the Los Angeles Department of Mental Health. A number of challenges faced by the Los Angeles MST project include the Probation Department's slow process of referring targeted youth to the program, covering the costs of uninsured youth, and the need to limit enrollment to youth in close proximity to the providers (since the providers must make frequent visits and be accessible round-the-clock).[108] With greater resources, program expansion and additional training, many of these challenges can likely be overcome.

Functional Family Therapy (FFT) {Proven Program}

What is the Program?

Functional Family Therapy (FFT) is a family preservation program targeting at-risk youth with a history of delinquency and youth transitioning from the juvenile justice system back into the community. The goal of FFT is to motivate youth and their families to change their negative behaviors by uncovering and building upon the family's unique strengths. The FFT approach is similar to that of MST, although the FFT program is generally shorter and less intensive.

What are the Key Components of the Program?

The FFT model involves multiple phases which are designed to help youth and their families identify their motivation to change, improve communication skills, and ultimately, learn to apply their new behavioral skills to interactions with peers, school personnel, law enforcement, and other community members. The FFT program specifically targets youth ages 11 to 18 with a history of delinquency, violence, substance abuse, conduct disorder, or other behavioral disorders. FFT providers work with the youth, parents and siblings in the home or other community settings. FFT is a three-month long intervention providing 8 to 12 one-hour sessions for mild cases and up to 26 to 30 hours of direct services to families in greater need. As compared to MST providers who have caseloads of four to six families and are available 24 hours per day, FFT providers have caseloads of 12 to 15 families and only work with the family during scheduled sessions. To insure program fidelity, FFT, Inc. disseminates the program and conducts training sessions for providers at FFT sites. The program has been applied successfully in several different ethnic communities.[109]

Who are the Providers?

The providers are Master's level therapists or Bachelor's level counselors supervised by a Master's level therapist. FFT, Inc. provides initial and ongoing training of the providers.

Who are the Collaborative Partners?

FFT has been provided collaboratively by probation departments, county departments of mental health, schools, juvenile courts, community mental health providers, and FFT, Inc.

Does it Work?

FFT is a "Blueprints proven" program, which has been found to reduce recidivism by 25 to 60 percent. In a study of an Ohio FFT program, five years after treatment, FFT youth had one-sixth the recidivism rate of youth in the control group. Kids in FFT, as well as their siblings, have also been found to have significantly lower rates of out-of-home placement and referrals to foster care than controls.[110]

Is it Cost-effective?

Cost-savings from reductions in incarceration and out-of-home placement have been estimated at $14,000 per child.[111] The average program cost per youth is $2,000.

What is its Implementation Status in California?

There is only one FFT program in California, although there are 80 FFT sites around the country.[112] California's FFT site is a collaboration between the Asian Community Mental Health Services and Roosevelt Middle School in Oakland. The program began in 2001, targets high-risk, truant, and acting-out kids and operates in English, Mien, Vietnamese, Cambodian, and Cantonese. The program currently serves 34 families.[113]

How is it Funded?

The Oakland FFT program is funded through a two-year federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant. Other FFT programs around the country draw from a variety of funding sources, including Medicaid, county general funds, state and federal violence prevention funds, and federal SAMHSA grants.

What is the Political Landscape?

There has been no organized advocacy effort behind FFT in California. Generally, the impetus behind the programs in other states has come from mental health providers, law enforcement, county administrators, juvenile court personnel and others who have read about FFT or heard about it at conferences on effective violence prevention or mental health programs. An ideal funding source for FFT in California is the Juvenile Justice Crime Prevention Act,[114] which funds local violence prevention efforts. An advocacy effort to educate policymakers about the cost-effectiveness of FFT could help increase funding for FFT in California.

Multidimensional Treatment Foster Care (MTFC) {Proven Program}

What is the Program?

Multidimensional Treatment Foster Care (MTFC) programs provide a supervised therapeutic living environment for youth with chronic delinquency and antisocial behavior. The goal of the program is to keep troubled youth in supportive home environments and out of residential placements or juvenile justice facilities. The underlying principle behind the program is that anti-social behaviors kids learn from peer influences and poor parenting can be corrected by temporarily placing the child with specially recruited families that provide positive reinforcement for good behavior and consequences for bad behavior. After their own behavior improves, and their biological or adoptive families develop better parenting techniques, the youths return to live with their own families.

What are the Key Components of the Program?

The program targets teenage youth with mental health problems who have a history of delinquency, are involved in the juvenile justice system, or are in the child welfare system. The MTFC program places participating youth with families from the community who are recruited and trained to set clear expectations, rules, and limits with follow-through on consequences, provide positive reinforcement for good behavior, and enforce separation of the youth from delinquent peers. Youth are not permitted to have unsupervised free time in the community, and their peer relationships are closely monitored. The monitoring levels may decrease over the course of the program depending on the youth's progress. The program also provides youth with individual therapy, teaches interpersonal skills, encourages participation in prosocial activities, such as sports, art or other hobbies, and provides mentors. The average length of the program per child is seven months. Referrals to MTFC programs come from county mental health and child welfare agencies, probation departments, and juvenile courts.

> **There is a lack of involvement with family. Mental Health is a family system issue, more so than an individual one and more focus on the entire family system would be more effective.**
>
> *-- Patricia Abadesco, Intervention Counselor, Union City Police Department*

In addition, the youth's biological (or adoptive) families receive family therapy and are trained to use the same structured MTFC system so the progress these children make does not evaporate once the youth return home. Parents practice their skills through closely supervised home visits with their child lasting one or two hours initially, and eventually including overnight visits. Once the child returns to the home of his biological parents, the parents are encouraged to participate in an after-care group that meets weekly and contact the case manager as needed. After-care services remain available to the family as long as needed, typically one year.

Who are the Providers?

MFTC foster parents are part of the treatment team along with program staff and therapists. After a 20-hour pre-service training, MTFC foster parents attend weekly group meetings where supervision is provided by a program case manager who coordinates the youth's treatment plan. Case managers call MTFC parents daily to check on the youth's progress and also maintain frequent contact with school personnel, the youth's probation or parole officer, work supervisors, health care providers and other involved adults. Case managers are trained in adolescent development, social learning prin-

ciples, and developmental psychopathology and must have at least a bachelor's degree. MFTC parents receive a monthly salary and a small stipend to cover expenses.

Who are the Collaborative Partners?

The MTFC program has been provided collaboratively with probation departments, county departments of mental health, child welfare agencies, and the Oregon Social Learning Center, which designed the program in 1983 and provides ongoing training and consultation to MTFC staff.

Does it Work?

The MTFC program is a "Blueprints proven" program. Evaluations have demonstrated that one year after treatment ended, youth who received MTFC treatment had less than half the number of arrests, spent fewer days incarcerated, and were one-third as likely to run away or be expelled from the program as control group youth in group homes. In a study of an MTFC program in Oregon which trained "regular" foster care parents already in the child welfare system, kids placed with foster parents who received weekly MTFC training had fewer problem behaviors and failed placements than kids with foster parents who received no additional training. In addition, foster parents who received the MTFC training were also less likely to drop out of the foster care system.[115]

Is it Cost-effective?

The estimated cost savings of the MTFC program based on the lower incarceration rates of MTFC youth two years after treatment is $60,000 per year. MTFC's cost per youth is $2,700 per month, or $18,900 for the seven-month program.

What is its Implementation Status in California?

The Blueprints model of the MTFC program described above has not yet been replicated in California. However, with the assistance of the Oregon Social Learning Center, adaptations of MTFC have been implemented in San Diego and Sacramento. The San Diego Health and Human Services Department and San Diego State University are collaborating to provide a scaled-down version of MTFC to prevent placement disruptions in the county child welfare system. The program provides foster parents already in the system (not recruited by the MTFC program) with additional management skills to better handle their acting-out foster children. The foster parents receive training and feedback during meetings once a week and phone calls twice a week. This adaptation of MTFC does not provide family or individual therapy. The San Diego program is the second year of its five-year funding.

River Oaks Center for Children in Sacramento offers another variation of MTFC, called Early Intervention Foster Support. It provides intensive support services for foster parents caring for infants and young foster children. The program is in its second year and currently serves about 35 foster families.

How is it Funded?

MTFC programs are generally funded by a variety of sources, including state and county general funds, social services funding, juvenile justice funding, and Medicaid for family or individual therapy treatment. San Diego's adaptation of MTFC has received $3 million in federal funding from the National Institute for Mental Health. The Sacramento adaptation received start up funding from the California Endowment and ultimately expects to obtain full Medi-Cal reimbursement for its services.

What is the Political Landscape?

There has been no advocacy effort to expand MTFC in California. In other states, law enforcement and juvenile justice personnel have shown great interest in the program as a way to reduce crime and juvenile justice costs. If the upcoming federal government review of state foster care outcomes indicates that California needs to reduce the rate that foster kids change placements, there could be an opportunity to advocate for MFTC programs, such as the one in San Diego, which trains foster care parents to better manage foster kids under their care and reduces placement disruptions.

Repeat Offender Prevention Program (ROPP) {Promising Program}

What is the Program?

Based on the premise that youth in danger of becoming chronic offenders can be identified and turned around when they first come in contact with the juvenile justice system, Repeat Offender Prevention Programs (ROPP) provide intensive services to high-risk, first-time juvenile offenders and their families. Orange County designed the first ROPP after studying the backgrounds and criminal histories of thousands of probation youth in the early 1980s and finding that 8 percent of the first-time youthful offenders committed a disproportionate share of juvenile crime. What distinguished the "8 percent" youth from other first-time offenders was that youths in the "8 percent" category all had at least three of the following four risk factors for crime: family dysfunction, substance abuse, school failure, and past delinquent behavior or gang affiliation.

What are the Key Components of the Program?

ROPP programs target youth 15 and a half years old or younger who are first-time offenders with significant family, drug and school problems, as well as past delinquency or gang affiliation. The programs collaboratively provide an average of12 to 18 months of individual and family counseling, substance abuse treatment, parenting classes, health referrals, on-site classes, after-school programs, employment training and job placement services, and community service opportunities. Some ROPP programs provide services at a central site and others refer participating youth to an array of public and private services in the region.[116]

Who are the Providers?

Probation officers identify eligible youth for the ROPP programs and take the lead in case management, although services are provided by all members of the collaborative team.

Who are the Collaborative Partners?

ROPP programs involve collaborations among county departments of probation, mental health, law enforcement, education, health, and child welfare, in addition to various community-based partners.

Does it Work?

Statewide evaluations of ROPP programs found that, 18 months after the programs began, ROPP youth had fewer new law violations, committed 30 percent fewer felonies, spent fewer days in custody, and showed greater academic improvement and school attendance rates than similar probation youth in control groups.[117] Evaluations did find that ROPP youth committed similar numbers of probations violations as the control youth 18 months after treatment began, which one probation official asserts is due to a variety of factors, most importantly, the higher level of probation supervision of ROPP youth as compared to control youth receiving typical probation services.[118] Depend-

ing on the results of the California Board of Correction's final evaluation of ROPP programs later this year, the ROPP program could be re-designated a "proven" program.

What is its Implementation Status in California?

Following Orange County's introduction of the program in 1994, 15 other counties in California have since implemented the ROPP program, serving more than 2,000 youth statewide. Counties with ROPP programs are Los Angeles, Fresno, Humboldt, San Diego, San Francisco, San Mateo, Solano, Kern, Kings, Monterey, San Bernardino, Santa Barbara, Tehama, Ventura, and Yuba.

How is it Funded?

ROPP programs initially received state funding as "demonstration projects" in 1997. State funding grew to more than $19 million in 2001-2002. State funding of ROPP programs will end in June 2002, however, and counties will have to seek other funding sources, such as the Juvenile Justice Crime Prevention Act, to initiate or continue their programs.

Is it Cost-effective?

Although there are no specific cost-savings estimates for ROPP programs, the federal Office of Juvenile Justice and Delinquency Prevention asserts that ROPP youths' decreased recidivism rates and fewer days spent in custody "could result in major, long-term savings."[119] Orange County's early estimate of their annual program cost per youth is roughly $14,000 as compared to incarceration costs of up to $54,000.[120]

What is the Political Landscape?

With 16 counties implementing ROPP programs, there is a strong base of support for the program at the county level among probation, other law enforcement agencies, and mental health departments. Since state funding is expected to end this year, counties will need a strong advocacy effort to secure other funding sources, such as the Juvenile Justice Crime Prevention Act, in order to extend their existing programs or initiate new ones.

Juvenile Mental Health Courts (JMHC) {Promising Program}

What is the Program?

Juvenile Mental Health Courts (JMHC), only recently developed, aim to improve youth mental health and reduce recidivism through a specialized juvenile court process that identifies juvenile offenders with mental health problems and provides them with needed treatment and case management.[121] The aim of the JMHC is to protect public safety while also preventing youth whose mental health problems may have contributed to their delinquency from being recycled through a juvenile justice system which is ill-equipped to rehabilitate them.

What are the Key Components of the Program?

In JMHC programs, mental health staff complete a mental health screening of all youth entering juvenile hall. If the screening indicates that a youth may have mental health problems, the juvenile offender may be referred to the JMHC, depending on his or her mental health history, the type of offense committed, and the current court caseload. JMHCs target youth with biologically-based mental health disorders that have contributed to their delinquency,[122] who generally have committed non-serious offenses,[123] and who want to participate. A multi-disciplinary team of staff from Probation, the County Department of Mental Health, the District Attorney's Office, and the Public Defender's Office decides which youth to refer to the JMHC. The purpose of the multi-disciplinary team is to have the various stakeholders share information, work together in a non-adversarial atmosphere, and try to reach consensus about how best to serve the needs of the youth, family, victims, and the community. After accepting a youth into the JMHC, the multi-disciplinary team members make recommendations to the court about the youth's mental health treatment and aftercare needs. Participating youth undergo a comprehensive mental health assessment, receive mental health treatment from community providers, gain access to other health and educational resources as needed, have frequent face-to-face meetings with Deputy Probation Officers, and make repeated court appearances.[124]

Who are the Providers?

Community mental health providers, in consultation with county mental health staff, provide mental health treatment, and Deputy Probation Officers or treatment facilitators take the lead in case management.

Who are the Collaborative Partners?

JMHCs require strong collaboration among county mental health staff, prosecutors, public defenders, judges, probation officers, and local community mental health providers.

Does it Work?

Since the programs are new, there has been no rigorous evaluation of their effectiveness. Outcome data from the Santa Clara JMHC's first year shows that none of the 43 participating youth have committed new law violations and only seven percent have committed probation violations since the program began.[125] According to Santa Clara County Deputy District Attorney Kurt Kumli, the JMHC is "not a magic bullet for delinquency, but it is a key that unlocks the door to services that can keep the kid from re-offending in the future." [126] The JMHCs were modeled after Juvenile Drug Courts, which have seven years of outcome data indicating that participating youth reduced their recidivism rates and increased their school participation and academic performance.[127]

Is it Cost-effective?

There have been no cost-savings analyses of JMHC programs. However, personnel involved with the Santa Clara court note that the program benefits the system through decreased recidivism, fewer unnecessary detentions, and expedited processing of the court's caseload, all of which are likely to result in substantial savings.[128]

What is its Implementation Status in California?

Currently, there are only two JMHCs in the United States, both in California. In February of 2001, Santa Clara started the first JMHC. Santa Clara's JMHC currently operates part-time, serving over 40 youth who are at home on probation. Psychologists and probation staff with small caseloads are assigned to the program. The Los Angeles Superior Court initiated its JMHC in the Fall of 2001 and currently serves over 30 youth. The Los Angeles court operates five days a week, serves youth who are at home on probation or who are in residential or locked facilities, and has psychologists assigned to the program. The probation staff in Los Angeles' JMHC are not assigned specifically to the JMHC and have larger caseloads than probation staff assigned to Santa Clara's court.[129] Since Los Angeles and Santa Clara began operating JMHCs, counties in other parts of California and the United States have expressed interest in creating similar courts in their jurisdictions.[130]

How is it Funded?

Santa Clara funds its JMHC using existing county resources,[131] while Los Angeles secured $1.5 million in Juvenile Justice Crime Prevention Act funding.

What is the Political Landscape?

In the two California counties with JMHCs, law enforcement, juvenile justice and the mental health community are in strong support. However, there may be a need to educate other law enforcement officials about the program to overcome possible hesitation about a separate juvenile court process for kids with mental health problems. The Santa Clara County District Attorney's office, for example, has heard some concerns from prosecutors in other states that JMHCs might become "excuse courts" that let kids off easily without holding them accountable.[132] Law enforcement and policymakers may need to be informed that youth participating in JMHCs must admit responsibility for the criminal offense before entering the program, and youth ultimately receive more intensive probation and court contact than juvenile offenders not in JMHC programs.

> **Too Many Times Children Virtually identify themselves to us, but a throrough assessment doesn't take place; hence we under-refer for early mental health services.**
>
> *-- Sheriff William Kolender, San Diego County*

In addition, some mental health advocates have expressed concern about the additional strain on already limited community mental health resources by JMHC judges ordering services for juvenile offenders.[133] Ideally, advocacy efforts at expanding JMHCs should include working with mental health advocates and juvenile justice personnel to increase community youth mental health resources so that children in need of early intervention, as well as juvenile offenders with serious mental illness, have sufficient access to needed services.

Youth Development and Crime Prevention Initiative (YDCP) {Promising Program}

What is the Program?

The Youth Development and Crime Prevention Initiative (YDCP) is a multi-disciplinary approach aimed at promoting youth mental health, reducing substance abuse and helping at-risk youth become financially self-sufficient. YDCP programs provide a coordinated delivery of mental health counseling, alcohol and substance abuse treatment, mentoring, job opportunities, and after-care assistance.

What are the Key Components of the Program?

The YDCP programs target youth who are engaged in or at risk of committing crime and abusing alcohol or drugs. Each YDCP program is unique, but all incorporate mental health treatment, drug and alcohol treatment, employment training, paid work opportunities, mentoring, and youth development projects. Some of the programs also actively seek participation of the youth's family. Programs are housed in probation facilities, schools, and other community facilities.

Who are the Providers?

Providers of the various program services are multi-disciplinary teams of therapists, drug and alcohol counselors, probation staff, workforce investment staff, youth development specialists, and Big Brothers/Big Sisters and other mentors.

Who are the Collaborative Partners?

The YDCP was developed collaboratively by the California Department of Mental Health, Alcohol and Drug Programs, and the Employment Development Department. At the local level, the programs bring together community mental health and substance abuse treatment providers, after-school providers, law enforcement, mentors, and local career centers.

Does it Work?

The programs are just getting off the ground in California and have not yet been evaluated. However, the YDCP was modeled after two federal programs, the Youth Offender Demonstration Grant Program and the One-Stop Youth Services Demonstration Model, which have very positive preliminary results. Of the federal program sites with the most comprehensive outcome data, only three to 15 percent of participating youth were re-incarcerated while 32 to 57 percent had obtained regular jobs. The evaluation credited the job training and placement services with the high level of youth interest and participation in the programs.[134]

Is it Cost-effective?

There are no published cost-savings estimates on either the YDCP or the federal model programs. Potential savings could include lower crime costs, fewer out-of-home placements, and less welfare dependency.

What is its Implementation Status in California?

Since the YDCP program began in 2000-01, seven California counties have received funding and are beginning to implement programs. Counties with YDCP programs are Butte, Mendocino, Sacramento, San Francisco, Santa Cruz, Solano, and Stanislaus. The YDCP was spearheaded by Grantland Johnson, Secretary of the state Health and Human Services Agency.

How is it Funded?
In total, the YDCP has received $6.1 million in funding through three federal programs, the Workforce Investment Act, the Mental Health Block Grant, and the Substance Abuse Prevention and Treatment Block Grant. Each funding source passes through a distinct department within California's state government: the Employment Development Department, the Department of Mental Health, and the Department of Drug and Alcohol Programs.

What is the Political Landscape?
Created and inspired by the head of California's Health and Human Services Agency, the YDCP clearly has strong administrative support in California. Because YDCP programs currently receive funds from three different state departments and funding streams, advocacy efforts at the legislative level will be needed to create a designated funding source and expand the program. Potential funding sources for program expansion include the Workforce Investment Act and the Juvenile Justice Crime Prevention Act.

Children's System of Care (CSOC) {Promising Program}

What is the Program?
Under the Children's System of Care (CSOC) model, children with serious emotional disturbances (SED) receive comprehensive mental health and other services through a multi-agency, integrated approach. The CSOC, which is essentially an innovative service delivery system approach, provides counties with the capacity and flexibility to deliver community-based, family-centered and culturally-appropriate services that improve child and family functioning, reduce recidivism, and reduce the need for placing kids with serious mental health programs in costly out-of-home placements. California's System of Care was initially developed in Ventura County in 1984.

What are the Key Components of the Program?
The principle underlying all CSOC approaches is to redirect resources away from institutional or out-of-home care to more coordinated and efficient family-centered services provided in the child's home and community. The CSOCs generally target kids who have Severe Emotional Disturbance (SED), are at risk of out-of-home placement, or have special education needs, although some counties open up CSOC eligibility to all kids in their public mental health system.

The CSOC model requires interagency partnerships, family involvement, and culturally-appropriate community services. Although specific program interventions vary from county to county, all CSOC programs include: (1) a multi-disciplinary assessment of referred youth to determine needs and establish service plans; (2) home-based mental health services; (3) school-based counseling programs: (4) family involvement and services such as parenting workshops, support groups and peer counseling; (5) juvenile justice programs that provide on-site crisis intervention and counseling, screening and follow-up; (6) wraparound services; (7) services to help older adolescents transition to adulthood; (8) emergency care and crisis intervention; and (9) minority outreach. The CSOC approach blends multiple mental health and other funding streams to help counties provide services not covered by any one funding source, such as prevention programs, case management, services for non-Medi-Cal youth, and cultural competence training.[135]

Who are the Providers?
Multi-agency teams provide the initial assessment. Case managers then work with staff from mental health, juvenile justice, social services, and education to deliver needed services to youth and their families.

Who are the Collaborative Partners?
In the CSOC approach, eligible kids and families receive a continuum of integrated services provided collaboratively by county mental health, juvenile justice, social services and education providers. The lead agency varies from county to county, but is often the County Department of Mental Health.

Does it Work?
Multiple evaluations of CSOC programs demonstrate a number of significant positive results for participating youth, as well as their families and communities. Results from a recent statewide evaluation of CSOC programs by the University of California San Francisco indicate that most kids participating in CSOC programs experience reduced recidivism, academic improvements, and reduced out-of-home placements. Virtually all youth receiving collaborative services by juvenile justice and mental health providers demonstrated reductions in the numbers of criminal charges one year after admission to the programs. In 19 of the 22 county programs evaluated, participating youth with past criminal histories had one-third as many sustained charges as they did before the CSOC programs began.[136]

> **THE SILOS OR SMOTESTACK NATURE OF THE RELATIONSHIPS BETWEEN ALL THE AGENCIES THAT PROVIDE SERVICES TO CHILDREN NEED TO BE PENETRATED.**
>
> *-- Sheriff William Kolender, San Diego County*

Youth receiving CSOC services in Merced county, for example, experienced a 56 percent drop in the number of criminal charges and a 91 percent drop in the number of probation violations four years after admission to the CSOC programs.[137]

Youth in Contra Costa and Riverside counties averaged more than one year of improvement on reading, math and spelling/writing tests. In Santa Cruz County, nearly 80 percent of kids in the CSOC programs improved their reading and math scores one year after treatment.[138] The research designs of individual county reports and UCSF's evaluation did not include control groups.

Is it Cost-effective?
The CSOC model saves counties money by reducing the number of kids in costly out-of-home placements. The UCSF evaluation estimated that California's implementation of the CSOC approach in 53 counties has cost taxpayers $159 million over the past decade but has saved $645 million in taxpayer costs for out-of-home placements alone. That is a savings of over four dollars for every dollar spent.[139]

What is its Implementation Status in California?
The CSOC model has been implemented to one degree or another in 53 of California's 58 counties. The original legislation, AB 3920 (Wright) created a pilot System of Care program in Ventura County in 1984. Later legislation, AB 344 (Wright) and AB 3015 (Wright), expanded the program

into additional counties. Although the CSOC target population of youth with Severe Emotional Disturbances (SED) is extensive in California, the volume of enrolled SED kids in CSOC programs is still relatively small.[140]

How is it Funded?

Cumulatively, California has spent $159 million on CSOC programs since 1984. State funding in recent years reached $44 million annually.[141] Federal, state and private grants have been used to establish the System of Care county infrastructures, while services are generally covered by Medi-Cal and other third party payors, state general funds for managed care, realignment funds, and grants.

What is the Political Landscape?

This year, Governor Davis proposed eliminating CSOC funding altogether and eliminating the ongoing independent evaluation of the CSOC by UCSF. However, mental health advocates and county mental health departments oppose those cuts and urge expanding the CSOC model in California to provide access to services for all eligible SED kids who are still unserved as well as kids whose mental health problems do not yet rise to the level of SED. One challenge to expansion is the diversity of program design among the counties. By identifying counties that have achieved better results, the recent statewide UCSF evaluation of CSOC programs should help newer CSOC counties replicate the successes of those counties with model CSOC programs.

Wraparound {Promising Program}

What is the Program?

Wraparound programs provide individualized and comprehensive services to youth with serious mental health needs by "wrapping" services around the child and family. Wraparound programs use funding that would cover the costs of out-of-home placements and instead spend it on family-centered, case management services in the home environment. The goal of Wraparound is to help youth and families avoid out-of-home placements.

What are the Key Components of the Program?

Wraparound is a case management approach that requires effective interagency collaboration and involvement by the youth and their families in developing treatment plans built on family strengths and supports. Wraparound programs target kids in foster care, probation, and special education programs, as well as other kids with Severe Emotional Disturbance that are either at risk of out-of-home placement or are returning from out-of-home placement. Some Wraparound programs only target youth with more serious mental health problems who are at risk of placement in moderate-level group homes while others broaden their target group to include youth who are also at risk of placement in lower-level group homes and foster family homes.

In partnership with Wraparound staff, the child, his or her family, and members of their support system work as a team to identify strengths, needs and goals, and develop a comprehensive service plan that is tailored to the needs of the family. Although the implementation of Wraparound programs may differ from county to county, all Wraparound programs promote success and permanency at home by (1) building upon family strengths and community linkages; (2) forging interagency partnerships; (3) assisting families design their own service plans; and (4) offering culturally competent services. Wraparound programs provide mental health services, social skills development, intensive case management, supervision and monitoring of community involvement, tutoring, parenting skills training and support, child abuse counseling, assistance with housing and transportation, crisis management, and general support services. Services are available 24 hours a day, seven days a week, and involve the delivery of needed services in the child's home, neighborhood, school, and community.

Who are the Providers?

Wraparound teams consisting of family specialists, a case manager, and parents work with the youth and family to design a comprehensive service plan. Clinical staff provide program support and monitor the goals and provision of services. Community partners provide many of the needed services in partnership with the lead agency and family.

Who are the Collaborative Partners?

Wraparound teams involve close collaboration among agency staff from county social service, mental health, probation, education, and drug and alcohol agencies, in partnership with community providers.

Does it Work?

Research shows that Wraparound programs can reduce crime and out-of-home placement. A 1996 University of South Florida study compared foster care children receiving standard services with those receiving wraparound services through a Wraparound program called Fostering Individualized

Assistance Program (FIAP). Post-intervention, boys who had participated in the FIAP program had significantly lower rates of delinquency than the control group youth. In addition, older foster youth with histories of incarceration and running away were less likely than controls to reoffend or run away after receiving Wraparound services. Youth in the FIAP group were also less likely to change placements and had better school attendance and fewer school suspensions compared to foster youth receiving standard services.[142] In Santa Clara County's Wraparound program, recent outcome data indicates that more than 30 percent of participating youth were able to move out of social service dependency or juvenile probation status after treatment.[143]

Is it Cost-effective?

Wraparound programs save taxpayer money by reducing both recidivism and costly residential placements. A study of Wraparound Milwaukee, a Wraparound model initiated in 1996, found that Wraparound services provided to youth at home cost 30 percent less per youth than group home care.[144] A study now being conducted by the University of California Berkeley Center for Social Service Research is expected to evaluate the cost-effectiveness of California Wraparound programs.

What is its Implementation Status in California?

California counties can implement Wraparound using federal or state funds. Currently 16 counties[145] in California have implemented state-funded Wraparound programs, serving 630 kids.[146] An additional 11 counties[147] are in the planning and approval process. The majority of counties with state Wraparound programs are still in the early stages of program development. Senate Bill 163 (Solis), passed in 1998, established the Wraparound Services Pilot Project which permitted counties to use state foster care funds to provide kids with case management services at home and avoid placing children in expensive residential facilities. The program is now no longer on pilot status and all counties can apply for funding through a State Department of Social Services approval process.

Five California counties (Alameda, Humboldt, Los Angeles, Sacramento, and San Luis Obispo) have implemented Wraparound programs through a federal Title IV-E statewide waiver permitting Wraparound programs to draw down federal foster care dollars. Currently, the federal Wraparound program serves just over 270 California kids.[148] The federal waiver requires evaluation using random assignment of individual children to treatment and control groups.

How is it Funded?

With approval by the California Department of Social Services, counties are permitted to use their federal Title IV-E foster care funds, state foster care funds, and county general funds to support Wraparound services in the youth's home in place of paying for group home care. California's Wraparound program also permits counties to blend their state and county foster care funds to provide services in a more flexible manner.[149]

What is the Political Landscape?

County governments, county welfare directors, child welfare advocates and providers such as Eastfield Ming Quan (EMQ) in Santa Clara County led the movement in California to create the state Wraparound pilot project and succeeded in urging the State Department of Social Services to obtain the federal Title IV-E waiver to allow counties to use federal foster care dollars to fund Wraparound programs. However, not all counties have access to Wraparound funding or the training needed to implement successful programs.

At the state level, the fundamental shift in the service delivery system required by Wraparound programs necessitates a greater focus on providing training and technical assistance to counties with new Wraparound programs. However, the state has reduced resources for technical assistance and training.[150] Expanding state Wraparound programs requires advocacy efforts to encourage and train additional counties to implement the Wraparound programs.

The strict evaluation requirements of federal Title IV-E waiver programs has become a practical barrier to implementation for many counties because of the extra costs and burdens associated with the required random assignment design.[151] Wraparound advocates are in favor of urging the federal government to remove the random assignment requirement once the federal waiver expires in 2003. Perhaps additional funding could be provided to cover the research component of the programs. In addition, once federal Wraparound programs have been successfully implemented, advocates may also urge extending Wraparound programs to youth in lower-level group homes and foster family homes, not just the moderate level group homes covered under the current guidelines.

Chapter 7: California Policy Recommendations and Action Plan

California Policy Recommendations

To prevent crime and fulfill the long-term commitment necessary to increase youth access to quality mental health programs, we make the following policy recommendations:

1. Support efforts to expand state and local funding of the Nurse Family Partnership program to serve more families in California.
2. Support efforts to increase state funding of School-Based Mental Health Centers to serve more youth in California.
3. Support efforts to increase state funding of the Early Mental Health Initiative to expand resources for Primary Intervention Programs (PIP) to serve more youth in California.
4. Support efforts to increase state and local funding Repeat Offender Prevention Programs (ROPP), Multisystemic Therapy (MST) programs, Functional Family Therapy (FFT) programs, Multidimensional Treatment Foster Care (MTFC) programs, Juvenile Mental Health Courts (JMHC), and Youth Development and Crime Prevention (YDCP) programs to serve more youth. A possible funding source for all of these programs is the state Juvenile Justice Crime Prevention Act (JJCPA).
5. Support efforts to establish a Mentally Ill Juvenile Offender Crime Reduction Grant program.
6. Support efforts to increase state funding of Youth Development and Crime Prevention programs through the Workforce Investment Act (WIA).
7. Support efforts to improve collaboration among the state and local agencies responsible for providing youth mental health services: departments of mental health, social services, education, and health, as well as the juvenile justice system. Such collaboration could be enhanced by increasing investment in Children's Systems of Care and Wraparound programs.
8. Support efforts to allocate additional tobacco settlement dollars to fund youth mental health programs.
9. Support efforts to urge the State Department of Mental Health to seek federal Medicaid waivers or legislative changes to both permit Medi-Cal reimbursement of mental health services provided to youth in the juvenile justice system as well as allow broader Medi-Cal reimbursement for home and community-based youth services for children with serious mental health needs.
10. Support efforts to mandate the mental health screening, assessment, and referral of all youth entering the juvenile justice system.
11. Increase resources for further evaluation of youth mental health programs to demonstrate their long-term effectiveness at reducing crime and saving money.

Each policy recommendation is described in greater detail below.

1. Support efforts to expand state funding of the Nurse Family Partnership program to serve more families in California.

Expanding Medi-Cal reimbursement as well as investment by California County Children and Families Commissions can help increase access to Nurse Family Partnership Programs in California.

Some counties in California currently receive Medi-Cal reimbursement only for a limited portion of Nurse Family Partnership services. Medi-Cal should be more accessible to these programs.

County "Prop 10" Children and Families Commissions are a potential source of increased funding for Nurse Family Partnership Programs. Approved by voters in 1998, Proposition 10, the California Children and Families Act, generates roughly $700 million dollars a year from a tax on California cigarette sales. This money is intended to provide a comprehensive, integrated system of early childhood development services for young children (prenatal to age five) and their mothers, including programs to educate parents on nurturing and child development, build child care skills, promote mental health, and provide prenatal and postnatal children services. To date, County Children and Families Commissions have provided partial funding of Nurse Family Partnership programs in seven of California's 58 counties.

2. Support efforts to increase state funding for School-based Mental Health Centers to serve more youth in California.

Although recent legislative efforts to expand state spending for school-based mental health centers have been unsuccessful, there is a growing momentum among mental health advocates to continue seeking expanded state support.

3. Support efforts to increase state funding of the Early Mental Health Initiative to expand resources for Primary Intervention Programs (PIP) to serve more youth in California.

California's Early Mental Health Initiative (EMHI), established legislatively in 1991 through AB 1650, provides funding for programs that enhance the social and emotional development of K-3 students. PIP annually receives $12 million of EMHI's total $15 million in state funding.

4. Support efforts to increase funding for Multisystemic Therapy (MST) programs, Functional Family Therapy (FFT) programs, Multidimensional Treatment Foster Care (MTFC) programs, Repeat Offender Prevention Programs (ROPP), Juvenile Mental Health Courts (JMHC), and Youth Development and Crime Prevention (YDCP) programs. A possible funding source for all of these programs is the Juvenile Justice Crime Prevention Act (JJCPA).

Established legislatively in 2000, the JJCPA allocates funds to California counties and cites to implement a comprehensive multi-agency juvenile justice plan to be developed by local juvenile justice coordinating councils. The JJCPA is California's largest investment of state general funds in youth crime prevention programs. First-year funding for JJCPA was $121 million in 2000-01 and was reduced to $116 million in 2001-02. In the May Revise to his 2002-03 budget, Governor Davis proposed a $111 million reduction of the JJCPA, effectively eliminating it. The JJCPA, however, is a

critical funding source of violence prevention programs.

JJCPA funds must be used to (1) assess existing law enforcement, probation, mental health, health, social services, drug and alcohol, and youth services resources that target at-risk youth, juvenile offenders and their families; (2) identify and prioritize neighborhoods, schools and other areas of the community that face a risk of juvenile crime; (3) create an evidence-based strategy that provides an integrated and comprehensive response to juvenile crime and delinquency; and
(4) provide services aimed at reducing juvenile crime and delinquency.

Counties have used their share of the funds for a variety of youth crime prevention initiatives, including mental health assessment and services for juvenile offenders, after-school programs, post-release programs for youth released from the juvenile justice system, substance abuse prevention services, truancy prevention programs, and gang intervention services. The JJCPA currently funds Los Angeles's MST project and Juvenile Mental Health Court. Many counties will seek JJCPA funding to continue their existing ROPP programs when the state's ROPP demonstration project ends this year.

5. Support efforts to establish a Mentally Ill Juvenile Offender Crime Reduction Grant program.

The Mentally Ill Offender Crime Reduction Grant program (MIOCRG) was established in 1998 through SB 1485 (Rosenthal) to fund county programs designed to curb recidivism among mentally ill adult offenders by addressing their in-custody and post-custody needs. The MIOCRG program has awarded a total of $50 million in grants to 15 counties. The MIOCRG, however, does not fund programs or services for mentally ill juvenile offenders. An MIOCRG program for juvenile offenders could fund MST, FFT, Juvenile Mental Health Court, ROPP and YDCP programs.

There was a legislative attempt last year to establish the Mentally Ill Juvenile Offender Crime Reduction Grants program. Senate Bill 1059 (Perata and Ortiz) proposed that the new program provide $2 million annually to counties to fund cost-effective approaches that address the mental health needs of juvenile offenders. Due to budget pressures last year, however, the bill's provisions extending the MIOCRG to juveniles were removed by amendment. The extension of the MIOCR program to juveniles had wide support including the California Peace Officers' Association; California Police Chiefs Association; California Healthcare Association; California Probation, Parole and Correctional Association; California Psychiatric Association; Commonweal; California Attorneys for Criminal Justice; California District Attorneys Association; California Catholic Conference; California State Association of Counties; Chief Probation Officers of California; and the Little Hoover Commission.

6. Support efforts to increase state funding of Youth Development and Crime Prevention (YDCP) programs through the federal Workforce Investment Act (WIA).

Currently, the YDCP receives only $3 million in funding through the Workforce Investment Act. The WIA allocates federal funding to states for the purpose of improving the job skills and employment opportunities of youth and adults. The funding has been used to support programs that provide job training, mentoring, tutoring, career counseling, and job placement services. Roughly $92 million, or 15 percent of California's share of WIA funding, is administered by the state California Workforce Investment Board at the discretion of the Governor for statewide initiatives and competi-

tive grants. The remaining $611 million, or 85 percent of the total WIA funding in California, is administered by the state Employment Development Department in cooperation with Local Workforce Investment Areas. Because YDCP programs provide at-risk youth with job training and employment opportunities, in addition to mental health counseling and drug treatment, the WIA is a potential source of expanding funding of YDCP programs across the state. Since Governor Davis' administration initiated the YDCP program, there may be promising opportunities to garner the Governor's support for additional WIA funding of the program.

7. Support efforts to improve collaboration among the state and local agencies responsible for providing youth mental health services: departments of mental health, child welfare, education, and health, and the juvenile justice system. Multi-agency collaboration could be enhanced by increasing investment in Children's System of Care (CSOC) and Wraparound programs.

The Children's System of Care is funded by the state general fund. In his May Revise to the 2002-2003 budget, Governor Davis proposed eliminating the CSOC program. However, increasing state funding of the Children's Systems of Care would expand youth access to needed mental health services in their home and community.

Counties can implement Wraparound programs using state funds or their federal foster care dollars. The fundamental shift in the service delivery system required by Wraparound programs necessitates a greater focus on providing training and technical assistance to counties with new Wraparound programs. Expanding access to state Wraparound programs also requires local advocacy efforts to educate and encourage additional counties to implement the Wraparound programs.

8. Support efforts to allocate additional tobacco settlement dollars to fund youth mental health programs.

As a result of the 1998 settlement of tobacco lawsuits brought against major tobacco companies by several states, California will receive a total of approximately $25 billion by 2025 to be divided by state and local governments. Each year, lump sum payments of between $400 million to $500 million are allocated to both the state and counties. County funds are distributed based on population, with county shares ranging from as little as $14 million to as much as $150 million for the largest county. While there are no restrictions on the potential uses of county settlement funds, health advocates have had some success at the local level in securing some of the local settlement dollars for public health programs. At least three counties, Napa, Sacramento, and San Diego, have earmarked tobacco settlement funding for mental health programs.

9. Support efforts to urge the State Department of Mental Health to seek federal waivers or legislative changes to permit Medi-Cal reimbursement of mental health services provided to youth in the juvenile justice system as well as allow broader Medi-Cal reimbursement for home and community-based youth services for children with serious mental health needs.

Currently, federal Health Care Financing Administration (HCFA) rules do not allow Medi-Cal reimbursement for most services provided in juvenile hall. As a result, the juvenile justice system is unable to provide adequate mental health services for the large numbers of juvenile offenders who have serious mental health needs. A federal waiver or legislative amendment to permit Medi-Cal

reimbursement for mental health services in the juvenile justice system would help these youth receive the services they need while in the juvenile justice system and as they transition back into the community.

With a federal waiver for home and community-based services, mentally ill kids who would become Medi-Cal eligible if institutionalized would qualify for Medi-Cal and be allowed to remain at home and obtain services in their community. Currently, a child who is removed from his or her home and placed in institutional care can qualify for Medi-Cal because only the child's income is counted (not the parents' income). One consequence of this eligibility rule is that many families who cannot afford services and are not Medi-Cal eligible find no alternative but to relinquish their child to the foster care or juvenile justice system so that the child can be eligible for Medi-Cal services. A federal waiver extending Medi-Cal to these kids would likely reduce the numbers of kids in costly institutional care, help maintain families, and assure that kids would get the mental health services then need in the least restrictive environment.[152]

10. Support efforts to mandate mental health screening, assessment, and referral for treatment of all youth entering the juvenile justice system.

To adequately address the mental health needs of juvenile offenders, all youth entering the juvenile justice system should be screened and assessed for mental health problems, and also referred for quality treatment if necessary. Implementing such a process may require stronger collaboration between the juvenile justice and mental health systems.

11. Increase resources for further evaluation of youth mental health programs to demonstrate their long-term effectiveness at reducing crime and saving money.

An expanded research base can persuade policymakers to increase resources for quality programs. Further evaluation showing "what works" can also help state and local agencies replicate quality programs and bring them to scale. In addition, collaborative approaches at the local level that have improved the delivery of youth mental health services should be closely studied to provide a blueprint for other counties in earlier stages of integration.

Action Plan

FIGHT CRIME: INVEST IN KIDS *California* proposes the following action plan:

- **Facilitate Working Group** — Facilitate the formation of a working group of allies to evaluate the political landscape, identify opportunities, set policy priorities, and begin to plan and put in place the policy, organizing and media work necessary to move forward.

- **Reach out to Law Enforcement** — Establish a Law Enforcement Youth Mental Health Advisory Committee to better understand the crime prevention issues from the perspectives of our law enforcement members, further explore their beliefs about needed reforms, and provide them with the evidence demonstrating that quality youth mental health programs prevent crime.

- **Form a Youth Mental Health Task Force** — Establish a statewide, diverse, and knowledge-

able task force to help shape the long-term youth mental health agenda of FIGHT CRIME: INVEST IN KIDS *California*. This committee, comprised of members of our current Ad-Hoc Youth Mental Health Advisory Committee, the Law Enforcement Youth Mental Health Advisory Committee, and additional advocates, providers, representatives from the juvenile justice system, and mental health agency leadership, would meet with various stakeholders, identify which issues are most ripe for change, and then identify next steps to launch a campaign to educate policymakers and others about the need to expand resources for effective youth mental health programs.

- **Begin a Campaign** — Based on the recommendations of the Youth Mental Health Task Force, FIGHT CRIME: INVEST IN KIDS *California* would take a lead advocacy role aimed at achieving two or three of the above California Policy Recommendations.

- **Publish Report(s)** — FIGHT CRIME: INVEST IN KIDS *California* would publish a full report or reports on the crime prevention benefits of quality mental health services and other violence prevention programs for at-risk and troubled youth, and propose policy recommendations.

    - This report would be distributed to relevant state policymakers, including the Governor, members of the Governor's Administration including the Secretary of the Health and Human Services Agency; the Director of the Department of Mental Health; the Secretary of the Youth and Adult Correctional Authority; the Director of the California Youth Authority; the Governor's legislative staff; all Legislators and targeted legislative staff; the Attorney General; and members of the media.

    - Law enforcement members of FIGHT CRIME: INVEST IN KIDS *California* would present this report to the recently established Council on Mentally Ill Offenders.[153]

Appendix A:

FIGHT CRIME: INVEST IN KIDS *California*'s Survey of its Law Enforcement Members Regarding Youth Mental Health Issues in Their Communities

In January 2002, FIGHT CRIME: INVEST IN KIDS *California* sent a written survey to 221 of its law enforcement members. The survey asked these law enforcement leaders about the youth mental health needs in their communities. Seventy-seven law enforcement leaders or their representatives completed the survey (the response rate was 35%). The survey's questions and results are as follows:

1. Do you believe that there is a strong link between youth mental illness and delinquent or criminal behavior?
   - 67% of respondents said YES
   - 33% of respondents said NO

2. Do you believe that there are sufficient treatment services for youth with mental health problems in your region or community?
   - 76% of respondents said NO
   - 24% of respondents said YES

3. What do you think are the most serious gaps in mental health services for kids in your community?
The most common responses were:
   - Lack of resources: qualified staff, facilities, professional counselors, money, and lack of information about where to refer kids with mental illnesses
   - Lack of early recognition and intervention of mental health illnesses
   - Lack of follow-up once the problem is identified
   - Lack of free or low cost services for mental health illnesses
   - Lack of parent/family acknowledgement of child's mental health problem

4. In your professional capacity, do you see youth entering the juvenile justice system with mental health problems?
   - 85% of respondents said YES
   - 15% of respondents said NO

5. Do you believe that there are sufficient treatment services for youth with mental health problems in the juvenile justice system?
   - 75% of respondents said NO
   - 25% of respondents said YES

6. Do you feel that youth transitioning back into the community receive adequate mental health treatment once they leave the juvenile justice system?
   - 85% of respondents said NO
   - 15% of respondents said YES

7. Do you agree or disagree that the following interventions work effectively to prevent mental disorders in youth and, ultimately, reduce crime?

*** Percentages reflect percentages of respondents**

(a) Child abuse prevention programs

- 39% strongly agreed
- 47% agreed
- 8% were neutral
- 6% disagreed

(b) Intensive intervention services for high-risk first time youthful offenders in need

- 50% strongly agreed
- 39% agreed
- 6% were neutral
- 5% disagreed

(c) Early intervention and support services for kids struggling at school or demonstrating anti-social behavior

- 59% strongly agreed
- 32% agreed
- 4% were neutral
- 5% disagreed

(d) Substance abuse programs for parents and youth with drug and alcohol problems

- 43% strongly agreed
- 35% agreed
- 12% were neutral
- 10% disagreed

(e) Mental health services in schools

- 32% strongly agreed
- 34% agreed
- 21% were neutral
- 13% disagreed

(f) Mental health services in the juvenile justice system

- 43% strongly agreed
- 35% agreed
- 16% were neutral
- 6% disagreed

(g) Mental health services in child care and preschool programs

- 25% strongly agreed
- 32% agreed
- 31% were neutral
- 12% disagreed

8. Which, if any, of the interventions listed below do you believe your community needs more of?

(a) Child abuse prevention programs

- 74% of respondents said YES
- 26% of respondents said NO

(b) Intensive intervention services for high-risk first time youthful offenders

- 93% of respondents said YES
- 7% of respondents said NO

(c) Early intervention and support services for kids struggling at school or demonstrating anti-social behavior

- 97% of respondents said YES
- 3% of respondents said NO

(d) Substance abuse programs for parents and youth with substance abuse problems

- 83% of respondents said YES
- 17% of respondents said NO

(e) Mental health programs in schools

- 76% of respondents said YES
- 24% of respondents said NO

(f) Mental health services in the juvenile justice system

- 87% of respondents said YES
- 13% of respondents said NO

(g) Mental health services in child care and preschool programs

- 63% of respondents said YES
- 37% of respondents said NO

9. Do you feel that early identification and intervention for children with mental health problems should be more of a public priority?

- 86% of respondents said YES
- 14% of respondents said NO

10. Do you believe that stronger partnerships between schools, child welfare agencies, county mental health programs and law enforcement would benefit kids with mental health problems and their families?

- 73% of respondents said YES
- 27% of respondents said NO

Appendix B: Program Contacts

Nurse Family Partnership
David Olds, Ph.D., Professor of Pediatrics and Director, Prevention Research Center for Family and Child Health, University of Colorado Health Sciences Center, Denver, 303.864.5205

Primary Intervention Program (PIP)
Robin Mandella, Early Mental Health Initiative Statewide Program Coordinator, California Department of Mental Health, 916.654.2131.

School-Based Mental Health Centers (SBMHCs)
Judy Barhydt, Director of Special Education, Pasadena Unified School District, 626.528.4531; and Janet Marquard, Director of School Health Services, San Fernando High School, 818.365.7517

Multisystemic Therapy (MST)
Marshall Swinson, MST Services Inc., 843.856.8226; and Andrea Gordon, Interagency Children's Services Consortium, Central Administrative Unit, Los Angeles Probation Department, 213.974.1334

Functional Family Therapy (FFT)
James F. Alexander, Ph.D., Department of Psychology, University of Utah, 801.581.6538; and Dr. Susan Ono, Asian Community Mental Health Services, 510.869.6095

Multidimensional Treatment Foster Care (MTFC)
Patricia Chamberlain, Ph.D., Principal Investigator and Clinic Director, Oregon Social Learning Center, 531.485.2711

Repeat Offender Prevention Program (ROPP)
Al Lammers, Field Representative, California Board of Corrections, 916.445.5790, and Dr. Shirley Hunt, Senior Research Analyst, Orange County Probation Department, 714.569.2160.

Juvenile Mental Health Court (JMHC)
Dr. David Arredondo, Executive Director, Solomon, 408.364.7069; and Kurt Kumli, Deputy District Attorney, Santa Clara District Attorney's Office, 408.792.2772

Youth Development and Crime Prevention (YDCP)
Dave Nielson, Chief, Children and Family Services, California Department of Mental Health, 916.654.2952

Children's System of Care (CSOC)
Bill Carter, Deputy Director, California Institute for Mental Health, 916.556.3480; and Abram Rosenblatt, Ph.D., Associate Professor, Child Services Research Group, Department of Psychiatry, University of California San Francisco, 415.502.6174

Wraparound
Jerry Doyle, Chief Executive Officer, Eastfield Ming Quan, 408.379.3790; and Cheryl Treadwell, Manager, Child Protection and Family Support Branch Integrated Services, California Department of Social Services, 916.323.6024

Appendix C: List of Interviewees

In researching this policy paper, staff of FIGHT CRIME: INVEST IN KIDS *California* gained valuable insight and information from the following individuals, all of whom generously agreed to be interviewed for the paper:

Howard Adelman, Ph. D., Co-Director, Center for Mental Health in Schools, UCLA Dept of Psychology
Mary Jane Alumbaugh, Training, Policy and Research Associate, California Institute for Mental Health
Bonnie Armstrong, Director of Advocacy and Community Development, Casey Family Programs
Troy Armstrong, Director, Center for Delinquency and Crime Policy Studies, California State Sacramento
David Arredondo, M.D., Executive Director, Solomon
Dr. William Arroyo, Medical Director for Children, Los Angeles County Department of Mental Health
Judy Barhydt, Director of Special Education, Pasadena Unified School District
John Berner, Ph.D., Lead Researcher on ROPP Programs, California Board of Corrections
Irene Borgfeldt, Associate Mental Health Specialist, Mental Health Planning Council
Maggie Brandow, Staff Attorney, Mental Health Advocacy Services
Alice Bussiere, Staff Attorney, Youth Law Center
Catherine Camp, Consultant, Senate Budget Committee
Bill Carter, Deputy Director, California Institute for Mental Health
Patricia Chamberlain, Ph.D., Principal Investigator and Clinic Director, Oregon Social Learning Center
Gary M. Christ, MSW, Senior Director, Juvenile Justice, National Mental Health Association
Judith Cox, Assistant Chief Probation Officer, Santa Cruz County Probation Department
The Honorable Raymond J. Davilla, Presiding Judge of the Santa Clara Juvenile Mental Health Court
Larry Dodson, Director and Juvenile Consultant, Los Angeles County Probation Department
Jerry Doyle, CEO, Eastfield Ming Quan
Margaret Dunkle, Director, Institute for Educational Leadership
Toby Ewing, Project Manager, The Little Hoover Commission
Richard Figueroa, Deputy Legislative Secretary, Office of Governor Gray Davis
Steve Fox, former Legislative Director, Los Angeles County Department of Mental Health
Patrick Gardner, Staff Attorney, National Center on Youth Law
Billie Jean Glover, Division Director for Infant, Toddler and Preschool Programs, River Oak Center for Children
Andrea Gordon, Special Assistant to the Chief of Detention Services Bureau, Los Angeles County Probation Department
Pam Hawkins, Family Coordinator, DHHS-Sacramento County
Susan R. Henderson, Managing Director, Disability Rights Education and Defense Fund, Inc.
Peggy Hill, Deputy Director, National Center for Children, Families and Communities, School of Nursing, University of Colorado Health Sciences Center
Shirley Hunt, Ph.D., Senior Staff Analyst—Research Manager, Orange County Probation Department
Gerald Ivory, Director, Camp Community Transition Program, Los Angeles County Probation Department
Chuck Jackson, Commander, Los Angeles County Sheriff's Office
The Honorable Clifford Klein, Presiding Judge of the Los Angeles Juvenile Mental Health Court
Doug Kopp, FFT Implementation Director, FFT Inc.
Kurt Kumli, Supervising District Attorney for the Juvenile Mental Health Court, Santa Clara County District Attorney's Office
Al Lammers, Field Representative, California Board of Corrections
Dr. Donald Lomas, Private Consultant to the Pasadena Unified School District
Dan Macallair, Vice-President, Center on Juvenile and Criminal Justice
Robin Mandella, Program Coordinator, Early Mental Health Initiative, California Department of Mental Health
Janet Marquard, Director of School Health Services, San Fernando High School
Judy Marshall, Probation Officer, Santa Clara County Probation Department
Dr. Stephen Mayberg, Director, California Department of Mental Health
Eleanor Moses, Supervising Parole Officer, Alameda County
Dave Neilsen, Chief, Children and Family Services, California Department of Mental Health
Sherry Novick, Chief of Staff, Assembly Member Dion Aroner

Dr. Susan Ono, Project Director, FFT project in Oakland, Asian Community Mental Health Services
David Panush, Assistant Fiscal Policy Advisor, Office of Senator John Burton
Sharon Razone, Research Analyst, Child Development Policy Advisory Committee
Melissa Reuland, Senior Research Associate, Police Executive Research Forum
John Rhoads, Chief Probation Officer, Santa Cruz County Probation Department
Sherri Rita, Staff Attorney, Protection and Advocacy Inc.
Victoria Rome, Legislative and Policy Coordinator, California Youth Connection
Dr. Abram Rosenblatt, Associate Professor, Child Services Research Group, Department of Psychiatry, University of California San Francisco
Larry Rubin, Probation Director, Los Angeles County Probation Department
Rocky Rushing, Consultant, Office of State Senator John Burton
Kay Ryan, Executive Director, Child Development Policy Advisory Committee
Rusty Selix, Executive Director, Mental Health Association in California
Bruce Slavin, General Counsel, Youth and Adult Correctional Agency
William Sparrow, Medical Administrator, San Diego County Sheriff's Department
David Steinhart, California Youth and Family Policy Consultant, Commonweal
Scott Stickney, Legislative Analyst, Los Angeles County Probation Department
Carol Straughn, Deputy District Attorney, Los Angeles County District Attorney's Office
Geri Summerville, Deputy Director, Replication and Expansion Services, Public/Private Ventures
Norma Suzuki, Executive Director, California Probation Chiefs Association
Cheryl Treadwell, Manager, Child Protection and Family Support Branch Integrated Services, California Department of Social Services
Dr. Louis Vismara, Commissioner, California Children and Families Commission
Jack Wallace, Youth Authority Administrator of Special Programs of Institutions on Camps Branch, California Youth Authority
Nick Warner, Legislative Advocate, California State Sheriffs' Association
Alan Watahara, President and General Counsel, The California Partnership For Children
Sandy Watkins, District Chief, Los Angeles County Department of Mental Health, Juvenile Justice
Linda Wolleson, Supervising Public Health Nurse, Monterey County Nurse Visitation
Greg Zinser, CEO, Vista Hill Learning Assistance Center

Endnotes

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[2] Little Hoover Commission, *Young Hearts and Minds*, p. 22.

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[9] Id.

[10] Coalition for Juvenile Justice, *Handle with Care: Serving the Mental Health Needs of Young Offenders*, 2000 Annual Report, p.11. See also the Little Hoover Commission, *Young Hearts and Minds*, p. 12.

[11] Steiner, p. 30.

[12] Soghor, p. 3.

[13] U.S. Department of Health and Human Services, *Mental Health; A Report of the Surgeon General*, pp. 127-132. See also Office of Juvenile Justice and Delinquency Prevention, *A Treatment Study of Children with Attention Deficit Hyperactivity Disorder*, U.S. Department of Justice, #20, May 2001, p. 1.

[14] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, pp. 127-132.

[15] U.S. Department of Health and Human Services, *Youth Violence: A Report of the Surgeon General*, U.S. Department of Health and Human Services, 2001, p.58.

[16] Little Hoover Commission, *Young Hearts and Minds*, p.21.

[17] U.S. Department of Health and Human Services, *Mental Health: A Report of the U.S. Surgeon General*, pp. 46-64.

[18] Little Hoover Commission, *Young Hearts and Minds*, p. 9.

[19] Widom, C., *Childhood Victimization: Early Adversity, Later Psychopathology*, National Institute of Justice Journal, January 2000, pp. 3-9.

[20] Child Welfare League of America, *Sacramento County Community Intervention Program: Findings from a comprehensive study by community partners in child welfare, law enforcement, juvenile justice, and the Child Welfare League of America*, June 1997.

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[24] The Sentencing Project, *Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription*, January 2002, p. 8. See also the U.S. Department of Health and Human Services, *Youth Violence: A Report of the Surgeon General*, p. 50.

[25] For more information on the methodology of the FIGHT CRIME: INVEST IN KIDS *California* survey of its law enforcement members, the specific questions asked, and the responses, see Appendix A.

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[33] Senate Floor Analysis, Assembly Bill 34, September 7, 1999.

[34] Brian Lee interview with William Sparrow, Medical Administrator, San Diego County Sheriff's Department, June 5, 2002.

[35] Id.

[36] Brian Lee interview with Commander Chuck Jackson, Los Angeles County Sheriff's Office, February 21, 2002.

[37] Senate Bill 1059 (Perata and Ortiz), 2001.

[38] These law enforcement organizations also supported an earlier version of the bill that would have extended the Mentally Ill Offender Crime Reduction Grant Program to juveniles, which was ultimately removed from the bill due to the state's fiscal constraints.

[39] Little Hoover Commission, *Young Hearts and Minds*, p.41.

[40] Id at 42.

[41] SGR Health Alliance, Executive Summary, p.22.

[42] SGR Health Alliance calculated that direct public and private spending in California on both adult and youth mental health disorders was $9.5 billion. They did not break down the spending on youth mental health services separately. SGR Health Alliance, p.23.

[43] Little Hoover Commission, *Young Hearts and Minds*, p.41.

[44] Id. at 21.

[45] Id. at 23.

[46] Id. at i.

[47] Marsenich, p. 17.

[48] Sentencing Project, p.12.

[49] U.S. Department of Health and Human Services, *Mental Health: Culture, Race and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001, p. 3.

[50] Rand Health, *Research Highlights on Mental Health Care for Youth: Who Gets It? How Much Does it Cost? Who Pays? Where Does the Money Go?*, Retrieved from www.rand.org/publications/RB/RB4541/, p. 2.

[51] U.S. Department of Health and Human Services, *Mental Health: Culture, Race and Ethnicity*, p. 3

[52] Steiner, pp. 9-14.

[53] SGR Health Alliance, p. 164.

[54] Schumacher, M., and Kurz, G.A., *The 8% Solution: Preventing Serious, Repeat Juvenile Crime*, Sage Publications, 2000, p.28.

[55] Little Hoover Commission, *Young Hearts and Minds*, p. v.

[56] Marsenich, p. 62.

[57] SGR Health Alliance, p. 167.

[58] Id. at 30.

[59] University of California San Francisco Child Services Research Group, *California Children's System of Care Evaluation Report*, 2001, p. 23.

[60] Interview with Larry Dodson, Director and Juvenile Consultant, Los Angeles County Probation Department, January 7, 2002.

[61] Interview with John Rhoads, Chief Probation Officer, Santa Clara County, October 18, 2002.

[62] U.S. Department of Health and Human Services, *Mental Health: Culture, Race and Ethnicity*, 2001.

[63] SGR Health Alliance, p. 160.

[64] Managed Risk Medical Insurance Board, *County Mental Health Services for SED Treatment Report*, Data Insights Report No. 7, March 2002.

[65] Little Hoover Commission, *Young Hearts and Minds*, p. 63.

[66] Arredondo, p. 4.

[67] Steiner, p. 47.

[68] Shumacher, p.13.

[69] Steiner, p. 61.

[70] Interview with Gerald Ivory, Director, Camp Community Transition Program, Los Angeles County Probation Department, November 1, 2001. See also Hartney, C. at 19.

[71] Id. at pp. 15-48.

[72] Soghor, p. 4.

[73] 42 C.F.R. Sec. 435.1009.

[74] SGR Health Alliance, p. 176.

[75] The Sentencing Project, p. 11.

[76] See Chapter 2 and Appendix A for further discussion of the FIGHT CRIME: INVEST IN KIDS *California* survey of its law enforcement members.

[77] Olds, D, et al, *Prenatal and Infancy Home Visitation by Nurses*, in Elliot, D. et al., eds. *Blueprints for Violence Prevention*, Center for the Study and Prevention of Violence, University of Colorado, Boulder, 1998, p. 28.

[78] In its "Blueprints for Violence Prevention" series of publications, the Center for the Study and Prevention of Violence at the University of Colorado, Boulder, identifies effective violence prevention programs that meet a very high standard of scientific evaluation.

[79] Olds, D., et al., *Long Term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior*, Journal of the American Medical Association, Vol. 280, No. 14, October 14, 1998.

[80] Olds, D., et al., *Prenatal and Infancy Home Visitation by Nurses: Recent Findings*, in The David and Lucile Packard Foundation, *Home Visiting: Recent Program Evaluations*, The Future of Children, Vol. 9, No. 1, 1999, p. 62.

[81] See The David and Lucile Packard Foundation, *Home Visiting: Recent Program Evaluations*, The Future of Children, Vol. 9, No. 1, 1999.

[82] Karoly, L., *Investing in Our Children: What We Know and Don't Know About The Costs and Benefits of Early Childhood Interventions*, RAND, 1998, p. 86. The savings were calculated in 1996 dollars. Some of the savings included a reduction in welfare costs due to the higher employment rates of home-visited mothers. The savings today would likely be smaller given the time limits currently imposed by welfare reform.

[83] Interview with Geri Summerville, Deputy Director, Replication and Expansion Services, Public/Private Ventures, October 29, 2001.

[84] Currently counties are using county funding sources to cover the state share of Medi-Cal for these programs.

[85] There are currently more than 2,000 schools with PMHP programs around the country. U.S Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, p. 135.

[86] Id. at 136.

[87] Duerr Evaluation Resources, *Multi-Year Analysis if WSI Data for Fiscal Year 1997/98 EMHI Funded Program Participants*, California Department of Mental Health, March 2002. The evaluation did not entail a randomized experimental design.

[88] Duerr Evaluation Resources, *EMHI Statewide Evaluation Report*, California Department of Mental Health, 1999/00, p. C-8.

[89] California Department of Mental Health, *The Early Mental Health Initiative: Fiscal Year 1998-1999*, April 2001, p. 20.

[90] Senate Appropriations Committee analysis of AB 1980, August 2000.

[91] A few school-based health centers provide services at the site of a local community provider and while others may have one on-campus center serving a cluster of schools. Coray, G., *Update of California School-based and School-linked Health Centers*, California Association of School-based/School-linked Health Programs, June 2000, p. 1.

[92] A few school districts permit schools to provide "sensitive" services, such as mental health treatment, without parental consent. Coray, p. 7.

[93] Armstrong, B., *Consortium Meets the Mental Health Needs of Children Where They Are—In the Schools*, Journal for the Community Approach, California Edition, Summer 2001, p. 16.

[94] Bureau of Primary Health Care, *School-based Clinics that Work*, Health Resources and Services Administration, U.S. Department of Health and Human Resources, 1993, p. 14.

[95] Bureau of Primary Health Care, *Healing Fractured Lives: How Three School-based Projects Approach Violence Prevention and Mental Health Care*, Health Resources and Services Administration, U.S. Department of Health and Human Services, 1994, p. A-30.

[96] Friedrich, M., *25 Years of School-based Health Centers*, Journal of the American Medical Association, Vol. 281, No. 9, March 3, 1999, p. 781.

[97] Coray, p. 1.

[98] Bureau of Primary Health Care, *School-based Clinics that Work*, Health Resources and Services Administration, U.S. Department of Health and Human Resources, 1993, p. 71.

[99] Interviews with Judy Barhydt, Director of Special Education, Pasadena Unified School District, January 4, 2002, and Dr. Donald Lomas, private consultant to the Pasadena Unified School District, February 27, 2002.

[100] Interview with Janet Marquard, Director of School Health Services, San Fernando High School, January 29, 2002.

[101] Coray, p. 8.

[102] Assembly Education Committee Bill Analysis for AB 971, April 18, 2001.

[103] Henggeler, S., et al., *Multisystemic Therapy*, in Elliot, D.S., eds. *Blueprints for Violence Prevention*, Center for the Study and Prevention of Violence, Blueprints for Violence Prevention, Book Six: Multisystemic Therapy, University of California at Boulder, 1998.

[104] Henggeler, S., et al., *Family Preservation Using Multisystemic Treatment: Long term Follow-up to a Clinical Trial with SeriousJjuvenile Offenders*, Journal of Child and Family Studies, 2, 1993.

[105] Henggeler, *Multisystemic Therapy*, p. 3.

[106] The range is based on the varying costs of incarceration and boot camps for juvenile offenders. Id. at 44.

[107] Interview with Andrea Gordon, Interagency Children's Services Consortium, Central Administrative Unit, Los Angeles Probation Department, January 14, 2002.

[108] Interview with Andrea Gordon, Interagency Children's Services Consortium, Central Administrative Unit, Los Angeles Probation Department, January 14, 2002.

[109] Alexander, J., et al., *Functional Family Therapy*, in Elliot, D.S., eds. *Blueprints for Violence Prevention*, Center for the Study and Prevention of Violence, University of Colorado, Boulder, 2000.

[110] Id. at 8 and 59.

[111] Id. at 47.

[112] Interview with Doug Kopp, Director of Implementation, FFT, Inc., March 13, 2002.

[113] Interview with Dr. Susan Ono, Program Director, Asian Community Mental Health Services, February 19, 2002.

[114] See Chapter 7 for a description of the Juvenile Justice Crime Prevention Act.

[115] Chamberlain, P., et al., *Multidimensional Treatment Foster Care*, in Elliot, D.S. et al, eds. *Blueprints for Violence Prevention*, Center for the Study and Prevention of Violence, University of Colorado, Boulder, 1998, pp. 41-46.

[116] California Board of Corrections, *Repeat Offender Prevention Project: Status Report*, July 2001.

[117] Id. at pp. 9-18. The evaluation included a randomized experimental design.

[118] Interview with Dr. Shirley Hunt, Senior Research Analyst, Orange County Probation Department, January 30, 2002.

[119] Office of Juvenile Justice Delinquency and Prevention, *OJJDP Fact Sheet: The 8% Solution*, U.S. Department of Justice, #39, November 2001.

[120] E-mail correspondence with Dr. Shirley Hunt, May 20, 2002.

[121] Interview with Kurt Kumli, Deputy District Attorney, Santa Clara County District Attorney's Office, January 22, 2002.

[122] For example, Santa Clara's Juvenile Mental Health Court targets kids who have developmental disabilities, organic brain syndromes or brain conditions with a genetic component. Arredondo, p. 6.

[123] The JMHC in Santa Clara only accepts juvenile offenders who commit low-level offenses and are at-home on probation, while Los Angeles's JMHC accepts youth who have committed more serious crimes unless they are gang members or a danger to the community.

[124] Arredondo, pp. 6-16.

[125] Id.

[126] Interview with Deputy District Attorney Kurt Kumli, January 22, 2002.

[127] OJP Drug Court Clearinghouse and Technical Assistance Project, *Juvenile Drug Court Activity Update*, Office of Justice Programs, June 15, 2001.

[128] Arredondo, p. 4.

[129] The Los Angeles JMHC hopes to eventually assign probation staff specifically to the court. Interview with Judge Cliff Klein, Supervising Judge of the Los Angeles Juvenile Mental Health Court, February 4, 2002.

[130] "Santa Clara County Superior Juvenile Court Celebrates First Anniversary of Juvenile Mental Health Court," News Release from the Juvenile Mental Health Court, February 14, 2002.

[131] Santa Clara has minimized costs in part because a principal community mental health provider has provided some pro bono consulting services to the court, and the limited number of county residential facilities force the program exclude youth whose mental health problems necessitate out-of-home placement in a residential facility. Interview with Judge Raymond J. Davilla, Presiding Judge of the Santa Clara Juvenile Mental Health Court, February 14, 2002.

[132] Interview with Deputy District Attorney Kurt Kumli, January 22, 2002.

[133] National Mental Health Association, "Mental Health Courts Must Protect Civil Rights," NMHA News Release, January 10, 2002.

[134] Employment and Training Administration, *Interim Report for the Department of Labor Youth Offender Demonstration Project Process Evaluation*, U.S. Department of Labor, 2001. The evaluations did not involve randomized experimental designs.

[135] UCSF Child Services Research Group, pp. 7-17.

[136] UCSF Child Services Research Group, pp. 230-237.

[137] Merced County Department of Mental Health, *Merced County Children's System of Care 2001 Outcome Report*, 2001, p.10.

[138] Santa Cruz County Children's Mental Health, p. 8.

[139] UCSF Child Services Research Group, p. 29. UCSF broke down the savings by governmental source: $128 million in state savings, $192 million in county savings, and $323 million in federal savings.

[140] SGR Health Alliance, p. 161.

[141] Little Hoover Commission, *Young Hearts and Minds*, p. 104.

[142] Clark, H. B., et al., *Children Lost Within the Foster Care System: Can Wraparound Service Strategies Improve Placement Outcomes?*, Journal of Child and Family Studies, 5, 39-54, 1996.

[143] EMQ Children and Family Services program UPLIFT: *Wraparound Service Report*, EMQ Children and Family Services, September 2001, p. 21.

[144] Kamradt, Bruce, *Wraparound Milwaukee: Aiding Youth with Mental Health Needs*, Juvenile Justice—Youth with Mental Health Disorders: Issues and Emerging Responses, Vol. VII, No. 1, Office of Juvenile Justice and Delinquency Prevention, April 2000.

[145] The 16 counties with active Wraparound programs are: Alameda, Butte, Humboldt, Los Angeles, Mendocino, Napa, Orange, Placer, Sacramento, San Diego, San Joaquin, San Mateo, Santa Clara, Siskiyou, San Luis Obipso, and Tehama.

[146] E-mail correspondence with Cheryl Treadwell, Manager, Child Protection and Family Support Branch, Integrated Services, California Department of Social Services, May 6, 2002.

[147] Counties planning to implement Wraparound include: Del Norte, El Dorado, Monterey, Plumas, Riverside, San Bernardino, San Francisco, Solano, Lassen, Shasta, and Santa Barbara.

[148] E-mail correspondence with Cheryl Treadwell, Manager, Child Protection and Family Support Branch, Integrated Services, California Department of Social Services, May 6, 2002.

[149] California Institute for Mental Health, *Financing Social Supports and Services for Children and Families*, Cathie Wright Technical Assistance Center Newsletter, Vol. 2, Issue 4, July 1999.

[150] E-mail correspondence with Bill Carter, Deputy Director, California Institute for Mental Health, April 23, 2002.

[151] Cornerstone Consulting Group, *Child Welfare Waivers, Promising Directions, Missed Opportunities*, Retrieved from www.apsha.org/cornerstone/cwwappendix2.asp#california.

[152] Rita, S.., *Need for a Medicaid Waiver for Community-based Mental Health Services for Children*, Protection & Advocacy Inc., February 13, 2002. See also The Bazelon Center for Mental Health Law, *Making Medicaid Work to Fund Intensive Community Services for Children with Serious Emotional Disturbance*, September 1999.

[153] Signed into law in October of 2001, SB 1059 (Perata and Ortiz) created a Council on Mentally Ill Offenders to be administered by the Youth and Adult Correctional Agency. The primary goal of the Council is to investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending. Each year, the Council must submit recommendations for improving the cost-effectiveness of mental health and criminal justice programs in a report to the Legislature. The Council is comprised of the 11 members including the Secretary Youth and Adult Correctional Agency, the Director of Mental Health and other members appointed by the Senate Rules Committee, the Speaker of the Assembly, the Attorney General, and the Chief Justice of the Supreme Court. Appointments to the Council have not been completed and no meetings have yet taken place.

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