Promising Practices for Meeting the Mental Health Needs of Youth in Juvenile Justice Facilities

Report to

The Massachusetts Suicide Prevention Task Force

September 2004

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The concerns about youth in the juvenile justice system with mental health disorders[1] are longstanding. These concerns are multidimensional, ranging from recognition that the youths' mental health problems 1) may have led to their criminal acts; 2) may compromise their responses to rehabilitation; 3) may disrupt the rehabilitation processes for others in the correctional setting; 4) may require different interventions, including medication; and 5) may pose problems of providing safety for those youth or for others (Lynam, 1996; Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; Boesky, 2002; Wasserman, Ko, & McReynolds, 2004).

Over the past 12 years, there has been a continual and increasing focus on this population, from the standpoint of 1) understanding the extent of the need, 2) examining public policy regarding services to this population, and 3) identifying and systematizing promising practices. Numerous studies, both national and within states, have yielded estimates of need ranging from 25%-50% (Otto, Greenstein, Johnson, & Friedman, 1992; Virginia Policy Design Team, 1994; Bilchik, 1998; Cocozza & Skowyra, 2000; Washington Juvenile Rehabilitative Administration, 2001). A recently published report (Wasserman, Ko, & McReynolds, 2004) indicates that, based on their responses to the Diagnostic Interview Schedule for Children (DISC), only 32.8% of incarcerated youth did not meet the criteria for psychiatric disorders in the previous month; which means that 67.2% of the population did meet the criteria for one or more disorders. These figures are is approximately twice that of the general population of youth (Costello & Angold, 1998; Burns, 1999).

Estimates of the number of youth in the juvenile justice system with mental health disorders is dependent on the policies of each state that determine which youth are diverted from the juvenile justice system and which are kept within that system. In states where youth with diagnosable serious mental health disorders are treated within the mental health system rather than the juvenile justice system, the

[1] To include substance abuse

estimates are lower. The issue is further confused by whether or not the identification of these youth is based on screening at the time of admission or involves an ongoing review of mental status. The issue has also been clouded by definitional problems, that is, which disorders are considered mental health disorders and which are "correctional" disorders and how to determine which system should be responsible for these youth.

The State of Washington Mental Health Design Proposal (2001), which is based on the policy that these youth are best served within the juvenile justice system, captures the problems of designing appropriate mental health services by listing the following:

- Confusion across multi-service delivery systems and juvenile justice (at both policy and practice levels) as to who is responsible for providing services to these youth;
- A lack of adequate screening and assessment tools necessary to appropriately define the mental health population
- Few treatment systems based on "continua of care" models;
- A lack of training, staffing, and programs necessary to deliver mental health services within the juvenile justice system; and
- A paucity of research that adequately addresses the level and nature of mental health disorders experienced by these youth and the effectiveness of treatment models and services.

Nonetheless, progress has been made over the past five years in some states to address these policy issues and identify better or promising practices. This effort was moved forward by the publication by the Office of Juvenile Justice and Delinquency Prevention's publication of an "ideal" system of care (quoted in Washington State's Mental Health System's Design Proposal, 2001) that included the following:

- Appropriate mental health services for all juvenile offenders who need them;
- A continua-of-care model serving a full range of mentally ill youth, including those with multiple needs;
- Explicit goals for treatment and the provision of services appropriate to those goals;
- Access to treatment in the community for offenders involved in diversion and probation;
- Liaison and supervision between juvenile justice and mental health professionals, with availability for case management services; and

- Sensitivity to family needs, providing support and specific treatment to foster effective family functioning.

In 1999, the National Commission on Correctional Health Care published mental health standards for youth and adults with mental health disorders and these standards address issues of screening, assessment, treatment and transition and are required of institutions that wish to meet accreditation requirements. The Council of Juvenile Correctional Administrators published Performance-based Standards for Juvenile Correction and Detention Facilities in October 2003. These standards address issues of good care, safety, identification and treatment of mental health problems, and prevention of behavioral problems. The performance-based standards have been well-received and are being used in 18 states and are relevant to the work of the Suicide Prevention Task Force. See particularly the Safety Goal on pages 3-4 and the Health and Mental Health Goal on pages 14-19.

All these efforts represent a shift in juvenile justice system philosophy that prevailed in the 1990's—the "get tough" movement that was based on retribution and punishment (Cocozza & Skowyra, 2000). This "movement" involved sending more youth to adult court, longer sentences and lower ages at which juveniles could be prosecuted as adults, which Altschuler (1999) describes as the "adultification" of juvenile justice. Recently, Arredondo (2003) has placed the issue of youth with mental health disorders in the juvenile justice system in the context of child development to focus thinking on how which kinds of services are expected to help these troubled youth.

To assist the Suicide Prevention Task Force's Committee on Promising Practices, a study was undertaken to identify promising practices and exemplary programs within institutional settings where good practices have been implemented. Information was gathered through a review of the recent literature, interviews with those involved in national studies and surveys, and interviews with those responsible for programs and services in states or communities identified as exemplary. **The general finding, about which there is considerable consensus among "experts," is that although there are some good examples, in a few states, of better policies and practices, no state or program within a state is doing all that is recommended, that is, of establishing a comprehensive service system that meets all the standards of best practices or even promising practices.** However, the good examples are worth examining to understand more thoroughly the pieces of programs that could be put together into a high quality whole approach to these troubled youth.

Promising Practices

The promising practices related to youth with mental health disorders who enter the juvenile justice system exist along the continuum from intake to aftercare. For the focus on identifying promising practices within institutional settings, the task can be divided into three parts:

1. Screening/assessing/diagnosing prior to admission, both for the purposes of diversion and for the purpose of understanding the youth's needs if he/she does enter the institutional setting, and ongoing assessment of need during the youth's participation in the system;
2. Services, either community-based or within an institutional setting, to include treatment of identified needs, ongoing screening for emerging needs, planning for discharge and aftercare; also emerging interest in ombudsman services, and protection and advocacy services; and
3. Aftercare programs to ensure links to mental health treatment and other relevant community services.

The issue of how services in these three areas are provided is complex, and no clear path exists. This is particularly true related to whether or not the juvenile justice system provides these services, purchases them or depends on other public agencies to provide them. A major policy issue for this population is whether services are provided in an institutional setting or in small group care, usually defined as residential capacity under 12-15 youths. Further, regarding institutional/residential care, the issue is whether to create a full mental health treatment capacity within the correctional setting or to transfer youth with high needs to mental health facilities. There are examples of promising practices, using all of these approaches. The answer appears to lie in the state's policy decisions and funding decisions, rather than in any absolute or clear-cut advantage of one approach over another.

Exemplary Programs

A brief telephone interview was conducted to identify exemplary programs. Interviews were conducted with professionals in 1) juvenile correctional programs across the country; 2) national research and policy centers across the country; and 3) federal offices. Additional information was gathered from recent publications.

Programs in Juvenile Correctional Settings: In four states, strong initiatives have been identified that focus on meeting the mental health needs of youth in juvenile correctional settings.

- The State of Missouri uses a small group setting for all the juveniles in the youth correctional system and essentially provides milieu treatment in the

correctional system that would be hard to distinguish from a mental health treatment facility.

- Similarly, the State of Indiana Department of Corrections has developed a case management system within the juvenile correctional institutions that provides integration of the screening and assessment services, oversight of treatment and discharge planning.
- The State of Washington Juvenile Rehabilitation Administration has developed an evidence-based, mental health approach in treating mental health disorders, chemical dependency and sexual misconduct for all staff in three of its four juvenile correctional institutional settings. Revamping of the entire system has created an integration of screening and assessment, treatment within residential and non-residential settings and aftercare.
- The Texas Youth Commission has developed a mental health assessment and triage program and a mental health treatment setting, operated within the juvenile correctional system.

Screening, Assessment and Diversion Programs: In four states, strong screening, assessment and diversion programs have been identified and are considered noteworthy. Three are operated through strong partnerships between the courts and public mental health programs, and each operates slightly differently. One program, in Indianapolis, Indiana is operated through the court and a non-profit mental health entity established as a demonstration project.

- Santa Clara County Court for Individualized Treatment of Adolescents, Santa Clara County, California
- Wraparound Milwaukee, Milwaukee, Wisconsin
- Project Hope, Providence Rhode Island
- The Dawn Project, Indianapolis, Indiana

The Mental Health Court in Santa Clara County, California has developed a "hybrid" model that directs youth into mental health treatment services under the court's jurisdiction, but prior to adjudication. These youth must meet the criteria for biologically based disorders of the brain.

The other three programs, Wraparound Milwaukee (2000, 2004), the Dawn Project (2004) and Project Hope (2004) provide a good examples of community mental health programs that place a high priority on serving youth in the juvenile justice system. All three of these programs use a strengths-based, family-centered, system of care approach based on individualized service plans, multi-agency coordination and an array of formal and informal services.

Aftercare Programs: The programs listed above all provide ongoing links, some stronger than others, to youth while they are in correctional settings, and therefore provide good aftercare upon discharge.

Summaries of the eight programs mentioned above, the Missouri Division of Youth Services, the Indiana Department of Corrections, the State of Washington Juvenile Rehabilitation Administration, the State of Texas Youth Commission, Wraparound Milwaukee, the Dawn Project, Santa Clara County Court for Individualized Treatment of Adolescents and Project Hope, are attached.

Program Summaries

Programs in Juvenile Correctional Settings

State of Missouri Division of Youth Services, Department of Social Services
The Missouri Division of Youth Services (DYS) operates a comprehensive and integrated system of services to address the needs of youth who have entered the juvenile correctional system. This program has received wide acclaim as the best system in the country for children who have broken the law (Mendel, 2003), and the descriptive phrase used is "small is beautiful." The program has received accolades like the following:

- "Missouri is the best model we have out there." from Paul deMuro, an experienced and highly respected consultant to juvenile justice systems and former director of youth services in Pennsylvania
- "It works because they believe in the 'small is beautiful' theory." And "It's about high quality treatment in an intimate setting." From Barry Krisberg, president of the National Council on Crime and Delinquency
- "Why I think they're such a good system is that they have preserved the community aspect even in the secure programs. When you visit, you can see that they're not institutional. They've been able to preserve…a family atmosphere." From Ned Loughran, executive director of the Council of Juvenile Correctional Administrators
- The judges, program directors, state officials, legislators and others who have visited the Missouri system readily note the differences in the Missouri system and "often respond with surprise, even amazement, at the feeling of safety and optimism inside the (residential) facilities, and at the ability of Missouri youth to articulate a positive message and dispel the negative stereotypes that typically surround delinquent teens."

Another feature of the Missouri program that has caught the attention of juvenile justice experts and others is that there has not been a single suicide in the two decades since Missouri totally revamped its juvenile justice system, as reported by the Los Angeles Times (Warren, 2004). This figure was compared with the figure from the California Youth Authority of 15 suicides in the last eight years. The Los Angeles Times article also reported that 8% of the treated youth in the Missouri system ended up in adult prisons.

Each youth who enters the youth services system receives a comprehensive risk and needs assessment. The information obtained becomes the basis for the

Individualized Treatment Plan and helps to determine the youth's placement within the system. Regardless of the services the youth receives, he/she has ongoing and intensive relationships with professional staff—psychologists, counselors, teachers, case managers, case monitors, so assessment is an ongoing process. The Individualized Treatment Plan can be changed as needed, as can be the treatment that follows the plan.

The services provided by DYS for the juvenile justice population form a continuum of care from small, secure residential services to group homes to specialized alternative living programs (foster care) to day treatment programs to a jobs program. They support these services with case management, intensive case monitoring and a range of family services. The programs are clearly community-based, and even the most intensive, secure programs are tied to community activities. Treatment is an integral part of each program component and not an adjunct. All youth receive aftercare upon discharge from either residential or community-based programs. Each youth has a community services coordinator to ensure that he/she receives needed services and to supervise his/her activities.

The individual planning for each youth, the wide range of services available, and the integration of services across all levels of DYS programming are noteworthy, and unusual. However, the major difference between the Missouri system and those in other states lies in how residential services are delivered. Across the country, most juveniles who are confined are held in facilities of 110 or more (Mendel, 2003). During the 1980's, Missouri moved from the large training school concept to small residential facilities. Across the state, there are approximately 30 facilities that have a total of 725 beds for the residential programs, which include secure settings, moderate care facilities, group homes, and alternative living arrangements, (similar to foster care) and independent living. The first three of these settings serve essentially as substitutes for institutional care/confinement and provide intensive treatment and complete educational programs.

- *Secure settings:* The secure settings may house up to 30 youths. However, they are divided into treatment groups of 10-12, and the youth attend school, have recreational activities, meals and live in dorm rooms in these groupings. The facilities are enclosed by a locked, perimeter fence.
- *Moderate care:* These settings are similar to the secure settings in their size and grouping of youth. Several of these facilities are located in state parks. The facilities are an open dorm model and have no perimeter fencing.
- *Group homes*: These less restrictive settings have 10-12 beds and are located in community neighborhoods, on a university campus, or in state parks, as therapeutic camping sites. Staff provides 24-hour supervision,

although many of the activities are in the community, such as having jobs or doing volunteer work on community projects. Those in the camping programs may work as assistants to the park rangers, even to the extent of having uniforms to do so.

Within the residential programs, the treatment is total milieu treatment, meaning that every aspect of living, schooling, and recreation is tied to treatment goals and is designed to help each child toward rehabilitation. To facilitate parental participation, youth who are removed from their home communities are housed within 50 miles; if necessary, transportation for families is provided.

Throughout all aspects of the DYS services, the major focus is treatment, and is based on the recognition that each youth must feel physical and emotional safety before he/she can respond to treatment, and this is especially emphasized in the residential services. The power of peer group work is respected and promoted to facilitate feelings of safety, of belonging, and of acceptance. Much of the treatment evolves from group interactions, which are directed by staff to be therapeutic to the group members.

The program descriptions, in writing and verbally by staff, focus on meeting the individualized needs of children and their families, tailoring services to meet their changing needs, serving children in the community, encouraging parental involvement, understanding their diversity, and providing treatment in all aspects of services. There is little mention of the courts and the term "offenders" is rarely used—just "youth" and "families." Descriptions of the DYS comprehensive program are hard to differentiate from descriptions of mental health systems of care descriptions and one has to search to establish that indeed these programs are for youth in the juvenile justice system.

This system of care has a 15-member advisory board which includes judges, former legislators, civic leaders and concerned citizens. The advisory board acts as a liaison to the governor, the legislature, the judiciary and the general public. Additionally, there are community liaison councils to promote and maintain strong relationships between the DYS local programs/ facilities and their communities. The liaison councils are comprised of local citizens who serve as volunteers.

Cost for residential services: Approximately $120/day

Commentary: The Missouri system appears to be "head and shoulders" above most other systems in the country, particularly in its residential/institutional services. The system is based on a different approach than other systems and the

data indicate that this approach is working. Costs are extremely reasonable for residential services. It seems worthy of further study by the Suicide Prevention Task Force through an on-site visit to gain more information. If visits are to be made, it seems clear that this one cannot be left out.

Indiana Department of Corrections, Juvenile Services Division:
For the past five years, the Indiana Department of Corrections, Juvenile Services Division, has been making a concentrated effort to transform its services to youth in correctional settings with a focus on three major goals: 1) to improve the quality of services; 2) to increase the continuity of care; and 3) to establish a seamless system for its population. This reform effort has been system-wide, with state-level leadership. The improvements have been planned to be statewide, not concentrated in one facility; and there is strong state-level oversight, based on ongoing, standardized review, of progress toward the three goals.

The Indiana DOC had sought the help of the National Council of Crime and Delinquency to evaluate their service approach and to assist with improved methods of assessing risk for recidivism, need for services, and determining appropriate institutional placement. The result of this latter effort has resulted in a decision-making process that groups youth according to levels of needed services, rather than the former method of grouping youth according to offense. In other words, the services are based on the offender, not the offense. The Indiana DOC also studied the most effective, evidence-based approaches for youth in correctional settings, which led to the adoption of a Comprehensive Case Management System (CCMS), which is grounded in theory and research. This system is described as "theory-based" and is guided by principles of intervention having to do with risk, need, and programming responsive to individualized plans, together with effective, evidence-based treatment models and good aftercare. Aftercare planning begins at entry.

Although the services are individualized based on the youth's risks, needs, and plans, the Indiana DOC has developed a standardized approach for all youth in the facilities and across all of its ten facilities. There are four phases to the service plans: Intake Phase (2 weeks); Growth Phase (indeterminate); Transition Phase (minimum of 60 days) and Aftercare (indeterminate).

The Intake Phase involves the use of assessment tools in four areas: 1) educational/vocational; 2) substance abuse/mental health; 3) social/emotional/ problem solving/anger management; and 4) an assessment of family needs that are critical to the youth's returning home. In addition to the assessment tools, the

youth are interviewed by the clinical staff of psychologists and psychiatrists. Using the information obtained by the assessment process, the staff engages in a placement decision tree process that is based on the youth's level of risk and needs, rather than placement by level of offense, which was the former approach. Two of the ten facilities are designed for youth with exceptional programming needs, including youth with emotional disorders. These facilities, Pendleton and Plainfield, have the same programming as the others for the Growth and Transition Phases, but have more clinical staff available. Front line staff is trained to understand that these special needs have to be addressed as a part of helping the youth grow through the basic program. Few youth are transferred to psychiatric facilities at this point, as the pre-disposition screenings are, for the most part, effective in identifying youth who need these services instead of youth correctional services. There is also the possibility of such transfers during the youth's stay in corrections, should a serious mental illness be identified later.

During the Growth Phase, the CCMS is operational in all facilities. There is an individualized growth plan developed that involves specific treatment areas. Each youth has a case manager and a treatment team, which includes all the people involved in his/her care and treatment—that is, front-line custodial staff, teachers, recreation staff, supervisors, clinicians, etc. The treatment team participates, with the youth, in an ongoing (bi-weekly) review of progress during the Growth and Transition Phases. The focus on individualized service plans and the monitoring of these by staff at all levels provides for ongoing review and monitoring of the youth's behavior, needs, and progress. It also provides an opportunity to understand changes, new needs, and concerns.

The ten facilities are each divided into cottages or units of 24-30 youth per unit. Each case manager is responsible for a maximum of 16-18 youth. The overall staffing ratio per facility is 1:10/12. The facilities are accredited by the National Commission of Correctional Health Care. The cost of service is approximately $150/day, slightly higher at Pendleton and Plainfield.

During this Transition Phase, there is a careful assessment of aftercare placement possibilities, services needed, potential providers of those services and progress with the family environment. For youth identified at the time of disposition by the Chief Probation Officer as needing mental health interventions, community mental staff members are part of the CCMS team and attend case review sessions. They are also involved in aftercare planning for those youth identified while in the facility as needing mental health services as part of the aftercare plan, as described below.

The Aftercare Phase is planned from the time the youth enters the state facility. In most of the counties in Indiana, the aftercare is provided through the statewide adult parole system. However, in a few counties, there is a move toward county-based probation services specifically for youth. Indiana is moving toward a statewide community mental health program for youth using the system of care model. Youth on parole or probation fit into this model and are linked to community mental health for as long as they have mental health treatment needs.

The Indiana DOC conducts ongoing review of the effectiveness of their approach to youth using the Correctional Program Assessment Inventory (CPAI) (Gendreau & Andrews, 2000). The reviews are done by peers from sister facilities and are used as the basis of planning improvements.

Over the past five years, the State of Indiana has made a focused effort, with strong state leadership, to improve the youth corrections system. The system is managed at the state level by a clinical psychologist. Indiana has based the reform of their system on evidence-based methods and has provided training in the new approach (Comprehensive Case Management System) to all levels of staff, so that they can use the information from assessment and individualized treatment planning in all activities with the youth. They begin the discharge planning at entry and have developed ties to families and to community programs that can support both the family and the youth. They have built in a quality review, done by peers, to assess progress and areas that need attention.

Cost of residential/institutional services: Approximately $150/day

Commentary: The Indiana juvenile justice system appears to have more "promising practices" in place than many others do, particularly in its institutional settings. The leadership presented a workshop at the Congress of Correction in Chicago in August 2004 on the Indiana Comprehensive Case Management System and the Correctional Programming Assessment Inventory and this workshop was quite well-attended and well-received. It is considered by national groups as one of the leading systems across the country. The leadership strives to maintain quality through reliance on evidence-based practice and self-assessment. Costs are reasonable for residential services. It seems worthy of further study by the Suicide Prevention Task Force through an on-site visit to gain more information.

State of Washington Juvenile Rehabilitation Administration
State of Texas Youth Commission

In addition to reviewing the systems in Missouri and Indiana, two other state systems were reviewed, the State of Washington and the State of Texas. Both of these states were mentioned as leadership states in the survey and the services they provide seem noteworthy. However, for the purposes of the Suicide Prevention Task Force, the services in Missouri or Indiana seem more relevant. Thus, only brief commentary is provided.

Washington Juvenile Rehabilitation Administration

The State of Washington has made a considerable commitment to improving services to delinquent youth, especially those with mental health or behavioral problems. They have produced exemplary system design plans to create changes in their system, which includes both non-residential and residential/institutional services. They have implemented a system-wide training program for direct-care staff at all levels of responsibility in evidence-based practices, both for assessment and for treatment. They have placed considerable emphasis on their staff and contracted providers using these approaches. Initial studies of the impact have yielded modest positive findings, but the approach is still quite new. The approach is laudable, but is too new to determine impact at this time. It is certainly a system that bears watching.

State of Texas Youth Commission

The State of Texas Youth Commission has developed a mental health system within their juvenile justice system to meet the needs of delinquent youth. The system provides an intensive evaluation of each youth in a centralized residential center. The youth stay in the diagnostic center until the evaluations are completed, which is usually about six weeks. Placements and service plans are derived from the evaluations.

They have dedicated one of their residential/institutional facilities (Corsicana) to intensive mental health treatment for youth who are diagnosed during the evaluation to have very severe mental health disorders. Other youth, who demonstrate serious problems in other placements, can be transferred to the intensive setting. The facility is staffed with well-trained personnel, plus special education teachers, social workers, and psychologists; psychiatrists are under contract for 4-5 days per week. The program is similar to a psychiatric hospital setting, with step-down services as the youths show improvement.

Throughout their residential system, the Texas Youth Commission provides intensive training to their staff in mental health treatment, suicide prevention, and quality care. They have mental health professionals available in all settings to review youth and to oversee treatment, or to recommend transfer to Corsicana.

The Texas Youth Commission reports to have implemented a traditional, but high quality response for youth with serious mental health disorders. The leadership has created services that do not exist elsewhere for their youth and work to maintain the services at high quality. The treatment programs meet the accreditation standards of the American Corrections Association.

Screening, Assessment and Diversion Programs

Wraparound Milwaukee, Milwaukee, Wisconsin
The mission of Wraparound Milwaukee is to provide cost effective, comprehensive and individualized care to children with complex needs and to their families in Milwaukee County. Wraparound Milwaukee is designed as a unique type of health maintenance organization that promotes collaboration among child welfare, juvenile justice, mental health and education in the treatment of children with serious emotional, mental health and behavioral challenges. It engages families as equal partners in the care of their children. The program is designed to provide community-based alternatives to residential treatment, juvenile correctional institutions, and psychiatric hospitalization. The program serves approximately 700 youth per year, of which 60-65% are adjudicated delinquent. Of the non-adjudicated group, many youth have been involved in criminal activities but have been diverted into treatment programs prior to adjudication. Wraparound Milwaukee has been presented as an example of effective community programming in the *President's New Freedom Commission on Mental Health* (2003). This program also demonstrates promising practices related to funding issues, family involvement, sustainability and impact on statewide policies. The program began in 1996 and serves approximately 900 youth per year.

Together with the partner agencies, Wraparound Milwaukee leads an integrated approach to services, using the strengths of the community agencies to address the needs of each youth and his/her family. The other community agencies provide financial support by through pooling dollars, which Wraparound Milwaukee manages for its system partners. Child welfare and juvenile justice provide these funds as case rates, along with a capitation rate from Medicaid for mental health and substance abuse treatment. Youth who enter Wraparound Milwaukee through the juvenile justice system receive the same diagnostic and treatment planning

services as all others; all the children in the program are considered non-categorically, but rather in terms of their service needs. The program offers an integrated, multi-agency/provider approach of individualized services to children and their families, based on their assessed strengths and needs, using a wraparound planning process. Much emphasis is placed on identifying youth and family strengths on which to build the treatment program.

As the funds come into the program non-categorically, there is considerable flexibility in how the funds are used. Care coordinators are the hub of the system, organizing the child and family team, arranging for community-based services, monitoring service delivery and impact, and being available to plan and troubleshoot with the family. The child and family team designs the service plan. The service plan is a mix of traditional[2] and non-traditional services, selected from an array of over 70 services and agencies, tailored to each child and family. This wide array of services results in a broad-based provider network, which allows families considerable choice of both services and providers. As part of the development of the system, Wraparound Milwaukee has trained and supervised the public and private providers/agencies in the community, so that the services they provide are consistent with program philosophy and quality practice. A strong parent organization helps to oversee the delivery of services and management of the program. Many of the service providers have strong ties to ethnic groups within the communities.

Wraparound Milwaukee covers the cost of all services that are part of the youth's service plan, unless the family has health insurance which will provide coverage or unless the family had financial means to do so. In Wisconsin, the counties are responsible for payments for placements in state institutions. Wraparound Milwaukee has maintained its good status (and funding) within the county by keeping the out-of-county placements to a minimum, both for psychiatric hospitalization and juvenile corrections.

Services follow the Child and Adolescent System of Services (CASSP) philosophy. They are individualized, child-centered, family-focused, culturally competent and community-based. The services also follow the System of Care model in that the services are integrated across the major child-serving community agencies. The services are also cost effective, in that, they result in good outcomes at reasonable cost. The program uses a strong data system to manage services and

[2] Traditional services are typically office-based counseling or therapy. Non-traditional services are those that are typically not based in offices or treatment centers. These services might include respite care, mentoring, or recreation therapy, as examples of non-traditional services.

funding, focusing on both quality assurance/quality improvement and on client outcomes.

Commentary: Wraparound Milwaukee is considered by many to be the best example of a community program for youth with mental health/behavioral problems. Their population is broad based, and unlike the CITA Program in Santa Clara County, Wraparound Milwaukee does not focus on a small population, limited by diagnosis. The array of services available to the client population is also quite broad and non-traditional. For the purposes of the Suicide Prevention Task Force, further study and visits to this program might be helpful, as the program includes both residential and non-residential settings, all with a heavy emphasis on the mental health/behavioral health of the youth and family.

The Dawn Project, Indianapolis, Indiana

The Dawn Project operates under the aegis of the family court and serves the children and adolescents of Marion County (Indianapolis), Indiana. The program was established in 1997 and serves approximately 150 children per year. Services are focused on children and adolescents in the child welfare system (child protective services and foster care) and the juvenile justice system. The project strives to provide new and improved levels of help and assistance to children with serious emotional disturbances and their families. Through collaborations with many different community partnerships and the use of flexible funding, the project has provided successful strength-based services to about 600 Marion County families. The project's focus is based on shaping an integrated system of care that is family-centered, community-based, culturally sensitive, outcome-driven, and fiscally accountable. Created in 1997, the project remains a collaborative effort among child welfare, special education, juvenile justice, and mental health leaders to serve youth with serious emotional disturbances and their families in Marion County. Apriority is placed on maintaining children in the community through intensive services rather than using psychiatric hospitals, juvenile correctional settings, or institutional-size foster care settings.

Funding for the program comes from a federal system of care grant and from the contributions of other agencies. The contributions are a combination of state and local funds available to the agencies. The agencies contribute funds to a pool, which the Dawn Project manages. Funds are pooled and expended according to a case rate. Using the case rate approach provides maximum flexibility to fund both services and supports needed by the child and family. The child and family team develops the service plan. Families have an active role on the team and a real choice of providers. The project has established a broad provider network for both

formal and informal services. The project team works to bring providers into the network through contracts and gets recommendations from the families, as well. They have developed mechanisms to support new, developing providers if they show promise of fulfilling the needs of the families. The family can interview the providers and decide which one(s) meet their expectations and requirements. The family also has a strong role, with the case manager, to monitor progress and decide if the services are going well. They can move to change providers, if they believe this is necessary.

Youth who enter institutional settings, who are considered to have mental health problems, are identified by the court and The Dawn Project staff provides case management services to these youth, working with the institutional staff to assist with a timely discharge. The Dawn project staff work to establish appropriate services for the youth so that the transitions and post-institutional services meet the youth's needs and help him to function well in the community.

Some Medicaid funds cover the case management and other services delivered that are through the county mental health agencies. The Medicaid funds follow a fee-for-service model. The project is working to enhance the use of Medicaid funding, as most of their clients are eligible for this entitlement.

Commentary: The Dawn Project is also considered an outstanding example of a mental health system of care. As this program is operated by the juvenile and family court, and exists in a state where the juvenile correctional settings are also considered to be exceptional, it seems that for the he Suicide Prevention Task Force, further understanding through an on-site visit could be very useful.

Santa Clara County Court for Individualized Treatment of Adolescents, Santa Clara, California

In February 2001, Santa Clara County, California opened the first mental health court for juveniles in the county, now called *Court for the Individualized Treatment of Adolescents (CITA).* This program was the result of many months of planning that involved the judiciary, probation, public mental health, district attorney, public defender, county government, and service providers. The goal of the program is to provide "a modern approach to mental health diagnosis, triage, and treatment services for youth and families who come in contact with the juvenile justice system as a result of the combination of serious mental illness and juvenile delinquency" (Arrendondo, Kumli, Soto, Ornellas, Colin, Davilla, Edwards, & Hyman, 2001). Working toward this goal has required assessing the youth from multiple points of view and bringing those together into a

comprehensive and coordinated plan. Achieving such coordination has required more changes in attitudes, understanding, training, and communicating among the involved professionals than actual changes in the form or structure of the system. The program exemplifies these changes, with full understanding and support from the judiciary, the court counselors, law enforcement, the district attorney and many local attorneys—all of whom are strong advocates for appropriate mental health treatment for youth.

The CITA program provides screening, intensive diagnosis and community-based treatment, and hospital treatment, as necessary, for youth who qualify. In the first two years of the project, over 300 youth were referred and approximately one-third were accepted. The program is limited to those youth who are diagnosed with biologically-based disorders of the brain, that is, major depression, bipolar disorder, schizophrenia, psychosis, severe attention disorders/hyperactivity disorders (ADHD), organic brain disorders, mental retardation, autism, Aspbergers Syndrome, and pervasive developmental disorder psychoses. The screening and diagnostic processes focus on identifying just those who meet the stringent criteria. Once a youth is screened into the program, local treatment resources are identified. The program serves approximately 75 youth per year, that is less than 2% of those who enter the juvenile justice system in Santa Clara County.

For youth who are screened out of the program, the California juvenile system is used. If youth develop mental health problems while in the California juvenile system, transfer to CITA does not occur, nor does the program provide consultation or training in screening, assessment or treatment to the institutional/ residential part of the juvenile correctional system.

This program is highly regarded within judicial circles and is being considered by judges for replication in other states, including communities in Alaska, California, New Jersey, and Ohio. The National Council of Juvenile and Family Court Judges has promoted understanding of this program (see First Monday publication, May 2004).

Commentary: The focus on identifying youth with serious mental health disorders and moving them into a treatment system is important and appealing to judges and others charged with decisions about the placement of youth. However, for the purposes of the Suicide Prevention Task Force, further study or on-site visits to this program at this time would be of limited value, as their priority is not on screening and diversion, but rather on services within the juvenile settings. Further, the array of treatment services is fairly traditional. At a later date, if

screening and diversion do become a focus, the CITA program in Santa Clara County could be a valuable resource.

Project Hope, Rhode Island

Project Hope, a partnership between the children's behavioral health and juvenile justice systems, is a statewide initiative for youth ages 12-21 with serious emotional disturbances. A primary goal is to develop a single, culturally competent, community-based system of care for these youth to prevent re-offending and re-incarceration. Another goal is to keep children from being sent to treatment facilities out of state. The project is in its seventh year of operation.

The community mental health program and a settlement house manage the project as a statewide initiative. The program participates in identification of youth to be diverted from the juvenile justice system and the after-care for those who enter the system with a focus on preventing re-entry to institutional programs. Rhode Island Training School for Youth assists in the transition into the community from the state's juvenile correctional facility. Similar to Wraparound Milwaukee, a broad population of youth with mental health/behavioral health problems is served.

Services provided use a wraparound approach, with a comprehensive service plan for each youth. A wide array of traditional and non-traditional services is available. The service plans are developed by the involved professionals, the family and the youth. Services are funded using a combination of state and federal grant dollars. The State of Rhode Island has a generous line item for wraparound services and these funds can be used very flexibly. A federal system of care grant pays for family services coordinators and for flexible services and supports.

The services and supports that are purchased are driven by a case plan developed with the family. Other relevant agencies also participate in the development of the case plan, but it is clearly a family-based system. There is a family advocacy council that advises state leadership.

A very broad Medicaid Plan, CHIP Plan and private insurance provide payments for the treatment services. The state has a Medicaid waiver that has a generous mental health benefit and provides for children at income levels up to 300-350% of poverty. The single state agency for children also has an agreement with private insurers to provide intensive outpatient services for children with serious emotional disturbances, up to three hours per week for six months. Given these options, most children and families can get the services they need.

Commentary: Project Hope serves approximately 125 youth per year and thus, is a smaller version of Wraparound Milwaukee. The state-level leadership has been successful with the insurance industry in getting a wide range of services included in private plans, similar to the state's Medicaid plan. Thus, almost all clients of Project Hope are covered and there is less use of state funds for all the client population, including the juvenile justice youth. In terms of usefulness to the Suicide Prevention Task Force, Wraparound Milwaukee would offer a broader perspective and more history regarding outcomes.

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