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deltaDIRECTIONS

Improving Mental Health and Substance Abuse Treatment in Juvenile Detention Facilities

Harvard Law School Mississippi Delta Project

Spring 2014

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I. Introduction[1]

Mental health and substance abuse treatment services are an essential component of a well-functioning rehabilitative juvenile justice system. These services are especially important in juvenile detention facilities, which contain a disproportionate number of juveniles suffering from mental illness due to the association between such issues and delinquency and the relative lack of services in the community.[2]

Maintaining detention centers is incredibly expensive, especially for juveniles with mental health concerns. In 2009, Mississippi spent approximately $93,000 per day maintaining its detention centers.[3]. Beyond the direct costs of maintaining these facilities, the state loses future revenues from incarcerated juveniles who spend 25-50% less time working during the decade after their release than their peers who had no history of incarceration.[4] Untreated mental illnesses and/or substance abuse disorders among this population further compound loss of productivity from both the juvenile suffering directly and from family caretakers.[5] Recognizing the increasing costs of sentencing more juveniles to detention, the legislature has worked to reduce both the number of juveniles in detention and the length of their sentences.

Working to reduce recidivism rates is another essential method for lowering juvenile justice expenses. Investment in mental health and substance abuse treatment before, during, and after youth are detained in facilities has been shown to reduce recidivism by 22% in states that aggressively invested in such programs.[6] Effective mental health treatment also reduces reliance on emergency and crisis care, drastically reducing healthcare costs for people with mental illnesses.[7]

This report addresses the current effort of state officials and legislators to continue its improvement of mental health and substance abuse treatment for youth involved in Mississippi's juvenile justice system, which in the past relied heavily on large detention facilities and training schools. As the state works toward improving mental

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[1] This report was prepared by Stephanie Berger, Carson Cook, Carmen Halford, Casey Holzapfel, Seth Packrone, Hudson Todd, and Amanda Savage, members of the Harvard Law School Mississippi Delta Project under the supervision of Desta Reff of Delta Directions. Special thanks to Lisa Lana, Dr. Angela Robertson, Patti Marshall, Francis Mendez, Dr. Christine Doyle, Emily Broad Leib and Ona Balkus of the Harvard Law School Mississippi Delta Project.

[2] Richard E. Redding, *Barriers to Meeting the Mental Health Needs of Offenders in the Juvenile Justice System,* 1 Juvenile Correctional Mental Health Report 17 (2001), *abstract available at* https://www.ncjrs.gov/App/publications/abstract.aspx?ID=187329.

[3] JUSTICE POLICY INST., THE COSTS OF CONFINEMENT: WHY GOOD JUVENILE JUSTICE POLICIES MAKE GOOD FISCAL SENSE 4, (2009).

[4] *Id*.

[5] COMM. ON THE PREVENTION OF MENTAL DISORDERS AND SUBSTANCE ABUSE AMONG CHILDREN YOUTH AND YOUNG ADULTS, NAT'L RESEARCH COUNCIL AND INST. OF MED. OF THE NAT'L ACADEMIES, PREVENTING MENTAL, EMOTIONAL, AND BEHAVIORAL DISORDERS AMONG YOUNG PEOPLE: PROGRESS AND POSSIBILITIES, BENEFITS AND COSTS OF PREVENTION (Mary E. O'Connell, Thomas Boat, and Kenneth E. Warner, eds., The Nat'l Academies Press 2009).

[6] JUSTICE POLICY INST., *supra* note 3, at 13.

[7] See, e.g., EA Latimer, *Economic Impacts of Assertive Community Treatment: A Review of the Literature*, CAN. J. PSYCHIATRY, 443-54 (June 1999)(showing that effective ACT programs can reduce hospitalization days by as much as 78%).

health and substance abuse treatment for these youth, it must implement creative programs that go beyond the former institutionally based model.

The report specifically analyzes innovations other states have developed to provide juveniles with evidence-based treatment while in the justice system, focusing on a New Mexico county's use of Medicaid rules to fund an alternative/transitional clinic as well as Louisiana's efforts to provide services more efficiently by increasing interagency communication. Further, the report reviews general reform patterns throughout the country including implementation of evidence-based treatment practices, development of alternative community placements, and reduction in detention facility populations.

A. Introduction to Juvenile Detention in Mississippi

1. Structural Overview of the Detention System

When a Mississippi youth court issues an arrest warrant or an order requiring a juvenile to be taken into custody, the juvenile is often taken to a detention facility operated by the county. Since only 16 of Mississippi's 82 counties have their own detention facilities,[8] a county without a facility may enter into a contract with a neighboring county-level facility, a state-level facility, or a private juvenile correctional facility to allow for the admission of its juvenile offenders.[9] The youth court that orders the juvenile into custody determines which type of facility is appropriate for the juvenile.[10] The Mississippi Department of Mental Health and the Mississippi Department of Human Services operate state-level facilities.[11] While the court has discretion to place a juvenile in a private facility, such facilities generally are not paid for by either the state or the county, and therefore are usually only a viable option if the family of the juvenile can bear the cost.

Mississippi law requires all juveniles to undergo a health screening within one hour of admission to a juvenile detention center, or as soon thereafter as reasonably possible.[12] While the law does not provide a more definite timeframe, it does direct facilities to screen juveniles during the intake process, which generally occurs within the first 24 hours of detention.[13] This health screening includes obtaining information regarding the juvenile's mental health and history of alcohol or drug use.[14] The screening is performed by a member of the detention staff who uses a standardized instrument such as the Massachusetts Youth Screening Instrument version 2.[15] If the screening indicates that a juvenile is in need of emergency medical care or mental health intervention services, the detention staff must refer the juvenile to a proper health

[8] Chris Davis, *Task Force Meeting to Consider Alternatives to Juvenile Detention*, SUPERTALK MISSISSIPPI (Oct. 3, 2012, 11:08 AM).
[9] MISS. CODE ANN. § 43-21-301.
[10] MISS. CODE ANN. § 43-21-315.
[11] *Id*.
[12] MISS. CODE ANN. § 43-21-321.
[13] *Id*.
[14] *Id*.
[15] *Id*.

care facility or mental health service provider for further evaluation as soon as reasonably possible.[16]

The county-level detention centers hold juveniles that are awaiting adjudication, have already been sentenced, have violated probation, or are waiting to be placed in a state training school.[17] County-level detention centers may not hold a juvenile for more than 90 days.[18] One county-level detention center, notable for its investment in support services, is the Henley-Young Juvenile Justice Detention Center of Hinds County. Its semi-military style program has capacity for 84 juveniles, and it provides short-term incarceration for youth that are awaiting a hearing or placement at a different facility.[19] Its program of "constructive discipline" includes psychological counseling, life skills training, and a full-time school with certified teachers.[20]

State juvenile detention facilities, operated by the Division of Youth Services (DYS) of the Mississippi Department of Human Services, provide pre-adjudication services, services for corrections, and aftercare supervision.[21] These additional services are provided through a training school, the Oakley Youth Development Center, and seven Community Service Division offices across the state that develop plans for the re-entry of juveniles into the community.[22] Only youth that are at least ten years old and have committed a felony or at least three misdemeanors may be admitted to a state training school.[23]

The Oakley Youth Development Center admitted 234 juveniles in 2012, slightly up from 199 in 2011.[24] The center provides treatment programs, counseling, and recreation to its youth, in addition to education at its own Williams School, a non-public school accredited by the Department of Education.[25] Each juvenile receives a full physical and psychological assessment, which includes an assessment of both suicide risk and trauma risk.[26] The center provides individual and group therapy that focuses on, among other things, social skills development, anger management, drug and alcohol awareness, and psycho-correctional skills.[27]

Youth courts may also order juveniles into the custody of the Mississippi Department of Mental Health, which is required to maintain two facilities, each capable of housing 50 juvenile offenders.[28] The Specialized Treatment Facility in Gulfport treats juveniles with mental illnesses, while the Mississippi Adolescent Center in Brookhaven

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[16] *Id*.
[17] NAT'L CTR. FOR JUVENILE JUSTICE, STATE JUVENILE JUSTICE PROFILES, 181 (2006).
[18] MISS. CODE ANN. § 43-21-605.
[19] HENLEY-YOUNG JUVENILE JUSTICE CENTER, http://www.co.hinds.ms.us/pgs/ctydivision/youthcourt.asp (last visited Oct. 11, 2013).
[20] *Id*.
[21] *Id*.
[22] *Id*.
[23] MISS. CODE ANN. § 43-21-605.
[24] DIV. OF YOUTH SERVS., MISS. DEP'T OF HUMAN SERVS., ANNUAL REPORT 5 (2012).
[25] DIV. OF YOUTH SERVS., MISS. DEP'T OF HUMAN SERVS., http://www.mdhs.state.ms.us/dys_instit.html (last visited Oct. 11, 2013).
[26] *Id*.
[27] *Id*.
[28] MISS. CODE ANN. § 41-21-109.

treats juveniles with intellectual disabilities.[29] These are the only detention facilities in the state that specialize in treatment.

Although the exact percentage of incarcerated juveniles in Mississippi that have a mental disorder and/or a substance abuse problem is unknown, approximations can be made based on data from previous years. For example, a 2004 study of 482 incarcerated juveniles in Mississippi found that 71-82%[30] (depending on assessment method)[31] of the participants had a mental disorder.[32] Mississippi's percentage was consistent with the national average of 73%.[33] The juveniles in the state training facilities[34] typically had a longer history with the juvenile justice system and have larger numbers of mental illness and mental disorders than at the county-level facilities.[35] The study also found that 31-36% of the juveniles had a substance abuse problem.[36] A previous national study found that approximately one-third of juveniles arrested or detained tested positive for at least one illegal drug.[37]

On October 27, 2010, there were 211 juveniles being held in public detention facilities in Mississippi, and 32 being held in private detention facilities.[38] However, those numbers are not necessarily representative of the total number of commitments made during the calendar year, since many juveniles are committed for less than one year. For example throughout 1998, 4,710 Mississippi youth were placed in detention centers pending case disposition and there were 1,762 commitments to one of the state's two training schools.[39] Assuming that the number of incarcerated youth has remained relatively constant and also assuming the accuracy of the percentages obtained through the 2004 study, each year, approximately 3,500 juveniles incarcerated in Mississippi have a mental health disorder, and approximately 1,500 have a substance abuse disorder. While these numbers are approximations, they provide a very general sense of the large numbers of incarcerated youth who have mental health and/or substance abuse disorders. A small number of these youth will be placed in Oakley Development Center where they will receive specialty treatment. However the remainder will likely be placed in county facilities that currently have limited resources to provide appropriate services.

2. Mississippi's Improvement of Mental Health and Substance Abuse Services

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[29] *Id*.
[30] Angela A. Robertson et al., *Prevalence of Mental Illness and Substance Abuse Disorders Among Incarcerated Juvenile Offenders in Mississippi*, 35(1) CHILD PSYCHIATRY & HUM. DEV. 55, 63, 65 (2004).
[31] The Adolescent Psychopathology Scale and Juvenile Detention Interview were conducted at juvenile detention centers, but not training schools due to time constraints. *Id*. at 58.
[32] *Id*. at 63-5.
[33] *Id.*
[34] At the time of the study, the state maintained two training schools, both of which provided juveniles for the study. One of the schools was subsequently shut down, leaving the Oakley Youth Development Center as the only facility operated by the Division of Youth Services.
[35] Robertson, *supra* note 31 at 63.
[36] *Id.*
[37] *Id.* at 66.
[38] U.S. DEPT. OF JUSTICE, OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, JUVENILE OFFENDERS AND VICTIMS: NAT'L REPORT SERIES 2 (2013).
[39] *Id.* at 56.

Despite the fact that the majority of Mississippi's incarcerated juveniles have a mental illness and/or substance abuse disorder, for many years the juvenile justice system lacked adequate treatment services to meet their needs.

Mental health treatment services for young persons in the juvenile justice system began and ended in detention facilities and training schools. The system did not provide mid-range alternatives to such facilities for youth who violated probation, resulting in an influx of incarceration and subsequent strain on the resources in these facilities.[40] Many of the individuals sent to these facilities were low risk offenders who did not need the intensive supervision these facilities are designed to provide. This strain led to superficial services, as one Justice Department investigation found that psychiatrists visited training school campuses only one day per month and spent most of their time performing court evaluations rather than providing treatment.[41] The study also found that counselors were assigned up to thirty juveniles, leaving little time for more than cursory checkups.[42] To compensate for this strain, juveniles were transitioned out of facilities quickly with little to no consideration of their progress.[43] The state lacked transitional services to assist these youth in accessing care in the community after they are released.[44]

Mississippi has taken great strides in recent years toward solving these problems and improving the quality of care young persons receive in juvenile justice facilities. In 2010 it reestablished the Commission on Children's Justice to evaluate and improve the Youth Court system, including the juvenile justice system. The Commission includes judges, educators, and child welfare professionals who have worked together to provide recommendations for the system's improvement. Over the past four years, the Commission has worked to create uniform standards for youth courts. The Commission has turned its attention towards improvement of mental health and substance abuse services. It can achieve this goal by utilizing successful strategies from other states.

a. Disparities Across Counties

One issue that continues to affect the quality of services juveniles in the justice receive is the disparity of available resources across counties throughout the state. Disparities in quality of services begin with the identification of offenders in need of mental health and substance abuse treatment. Because Mississippi detention facilities have such difficulty providing mental health services to its juvenile detainees, a robust system of identification and specialized placement would help allocate these resources

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[40] JOINT LEGISLATIVE COMM. ON PERFORMANCE EVALUATION AND EXPENDITURE REVIEW (PEER) REPORT TO THE MISSISSIPPI LEGISLATURE, JUVENILE JUSTICE IN MISSISSIPPI: STATE OF THE SYSTEM AND A STRATEGY FOR CHANGE, 50 (2007).
[41] David M. Halbfinger, *Care of Juvenile Offenders in Mississippi is Faulted*, N.Y. TIMES, September 1, 2003.
[42] *Id.*
[43] JOINT LEGISLATIVE COMM. ON PERFORMANCE EVALUATION AND EXPENDITURE REVIEW (PEER) REPORT TO THE MISSISSIPPI LEGISLATURE, *supra* note 41, at 51.
[44] *Id.* at 51.

effectively. However Mississippi lacks a system to guide courts in best practices for screening and placing youth into treatment best suited to meet their individual needs. This has led to an ad hoc placement system that varies greatly depending on a family's ability to pay for court-ordered treatment and the placements available for them.[45]

In 2007, the DYS began testing a pilot assessment program called the Youth Assessment and Screening Instrument (YASI) designed to limit the number of youth placed into state detention facilities to those in need of greater care.[46] DYS uses an electronic case management system to track the movement of juveniles through the two training schools and seven community offices and subsequently measure the effectiveness of these institutions in meeting their needs.[47] However, county facilities do not have access to this system, resulting in a lack of comprehensive data to evaluate county services,[48] and the state has yet to evaluate the success of this program.

County-to-county disparities in juvenile services occur at every stage of the justice system. Before charges are ever filed, school districts have the discretion to place students, including youth offenders, in alternative schools.[49] The availability of such schools varies greatly across counties. Disparities continue after charges are filed, as certain counties and municipalities have diversionary programs such as drug courts as well as crisis specialists who can refer juveniles to appropriate community services.[50] These deficiencies lead to over-dependence on state facilities that lack the capacity to provide the tailored treatment that community-based services can provide.

Most of the differences across counties are the direct result of each community's ability to pay for mental health services inside the justice system, such as wraparound services for juvenile offenders and their families, alternative placements, and qualified personnel within detention facilities. Counties also differ in their ability to invest in community-based services that can prevent many juveniles from entering the juvenile justice system.[51] Counties that cannot afford to pay for services both inside and outside the delinquency context tend to depend heavily on detention in state facilities. Therefore any attempt to continue to improve mental health services in the juvenile justice system will have to address funding concerns at the local level, as well as the state level.

B. Mississippi's Medicaid System

1. Medicaid and the Inmate Exception

Medicaid is the United States' health insurance program, used to provide coverage to specific groups, particularly low-income individuals. Youth who enter the juvenile justice system are often eligible for health care coverage through Medicaid;[52] however, federal statute does not allow for the use of federal financial participation

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[45] *Id.* at 52.
[46] *Id.* at 54.
[47] *Id.*
[48] *Id.*
[49] *Id.* at 56.
[50] *Id.*
[51] *Id.*
[52] NAT'L CONFERENCE OF STATE LEGISLATURES, JUVENILE JUSTICE GUIDE BOOK FOR LEGISLATORS 1 (2011), *available at* http://www.ncsl.org/documents/cj/jjguidebook-complete.pdf.

(FFP) funds to be used to cover any payments "with respect to care or services for any individual who is an inmate of a public institution."[53] This portion of the budgetary responsibility statute is known as the inmate exception.[54]

One of the largest problems with the inmate exception is its lack of clarity; many states saw the exception as an instruction to dis-enroll Medicaid-eligible inmates (including juveniles, to whom the statue does apply) from the program upon incarceration. This led to a lack of healthcare coverage among many inmates after their institutional release.[55] The federal government, recognizing the confusion, attempted to clarify the exception by stating that the inmate exception "excludes FFP for services provided to inmates of a public institution, but this does not preclude Medicaid *eligibility* for an individual who meets the eligibility criteria."[56] This means that eligible individuals do not lose their ability to receive Medicaid benefits upon release from the institution. States were further encouraged, but not explicitly required, to suspend rather than cancel Medicaid eligibility during an individual's incarceration so that such an individual would not have to re-apply for benefits upon release.[57] Results of this approach have been mixed across states.[58]

2. Inapplicability of Waivers to the Inmate Exception

The inmate exception is applies to all state public institutions, however, Medicaid has traditionally allowed states to apply for waivers to its regulations. These waivers have traditionally been granted for the following purposes: to enable research and demonstration projects, to fund the program through managed care rather than fee-for-service, to reimburse home and community-based services, and to apply a continuum of services for people who are eligible for both Medicaid and Medicare.[59] Theoretically, a state could apply for a waiver, under Section 1115 of the Social Security Act, to expand Medicaid coverage to youth in juvenile detention as a research/demonstration project. However, waivers obtained under this statutory provision apply over limited, specified time periods and are likely not a sustainable method for funding treatment services in juvenile detention centers.[60] In general, waivers to the inmate exception do not seem an attainable strategy for securing mental health services for juveniles in detention centers. No state currently has a waiver to the inmate exception.[61] Several states have obtained Medicaid waivers, however they do not apply to juveniles in this context. For example, when Maryland applied for a waiver to use Medicaid funding for juvenile mental health

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[53] 42 U.S.C. § 1396d(a)(27)(A) (2012).
[54] SUE BURRELL & ALICE BUSSIERE, THE "INMATE EXCEPTION" AND ITS IMPACT ON HEALTH CARE SERVICES FOR CHILDREN IN OUT-OF-HOME CARE IN CALIFORNIA iii (2002).
[55] Alison E. Cuellar et al., *Medicaid Insurance Policy for Youths Involved in the Criminal Justice System*, 95 AM. J. PUB. HEALTH 1707 (2005).
[56] BURRELL & BUSSIERE, *supra* note 55, at 11.
[57] *Id.*
[58] *Id.*
[59] *Waivers*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (last visited April 21, 2014).
[60] *Section 1115* Demonstrations, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html (last visited April 21, 2014).
[61] *Waivers*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (last visited April 21, 2014).

services, it could not include treatment delivered in a correctional facility.[62] Bernalillo County in New Mexico, discussed in detail below, was able to partially avoid the inmate exception by re-classifying certain members of its juvenile justice population. It did not obtain a waiver from Medicaid regulations.

3. Mississippi and the Inmate Exception

Because of the inmate exception, Mississippi currently does not receive Medicaid reimbursements for mental health and other medical treatment delivered within detention facilities or outpatient services delivered to inmates in the community. Mississippi only utilizes Medicaid funding for inmates who require temporary inpatient treatment in an external medical facility. According to a memorandum issued by CMS to all associate regional administrators, inmates who are temporarily released and admitted as inpatients in an external medical facility can receive Medicaid benefits if they are otherwise eligible.[63] Mississippi is currently taking advantage of this policy by releasing inmates experiencing medical emergencies or other serious health concerns to outside hospitals. Though helpful, this policy necessarily has a limited impact on the justice system because it only applies to the small population of inmates who qualify for inpatient services and are generally eligible for Medicaid.

The lack of Medicaid funding for inmates prevents Mississippi from using federal subsidies to pay for psychiatrists, counselors, individual and group therapy, appropriate psychotropic medications, and discharge planning for continued care in the community. If Mississippi were able to utilize Medicaid funding, it could greatly improve the availability and quality of these services for juveniles in the justice system.

II. Solutions From Other States

States throughout the country have faced similar challenges in providing adequate mental health and substance abuse treatment services to their juvenile justice populations. Some of these states have attempted to solve this problem through reform and innovation. The following section will discuss solutions used in other states as potential models for Mississippi in its effort to improve mental health and substance abuse treatment in its juvenile justice system.

A. New Mexico

1. Reform and Overview

[62] Telephone Interview with Dr. Francis Mendez, former CFO for the Maryland Department of Juvenile Services (Mar. 4, 2014).

[63] JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH LAW, THE EFFECT OF INCARCERATION ON MEDICAID BENEFITS FOR PEOPLE WITH MENTAL ILLNESSES (2009), *available at* http://www.bazelon.org/LinkClick.aspx?fileticket=_Ns68MefCJY%3D&tabid=441.

Bernalillo County, New Mexico, provides an exemplary model for dealing with issues of juvenile detention. The county has been able to shorten the length of juvenile detentions as well as lower the number of youth detained through improvements and expansion of mental health treatment.[64] In addition to strengthening the mental health care offered inside of Bernalillo's juvenile detention center, the county opened a mental health clinic, the Youth Services Center, to treat youth involved in the juvenile court system, particularly those who are detained pending the adjudication of their cases. This innovation provides judges with an alternative to incarceration for certain youth offenders, who are, instead, given probation and treated at the clinic. Previously, judges may have been inclined to sentence juveniles with certain mental health conditions to longer periods of incarceration in hope that they would received treatment in the detention facility. The clinic now provides these judges with an alternative to these long incarceration terms because it provides treatment to offenders after release.[65]

Before 2000, Bernalillo County's detention facility provided limited mental health services. Of the few staff members who were focused directly on providing mental health treatment, none had relevant advanced degrees.[66] Program leaders began reforming these services by creating new staff positions for "licensed mental health or substance abuse therapists" who had "the capacity to formally assess mental health needs and develop treatment plans for detained youth."[67] The county funded these positions through savings garnered from reduction in the size of its detention facility. Specifically, the county created a policy against incarceration of juveniles except in cases of serious and violent crime. This policy led to a reduction in the number of juvenile inmates. As its population decreased, the detention facility was able to close units and reduce its spending. With the enhancements to the mental health staff, Bernalillo saw improved treatment within the facility and improvements in outcomes of the youth being served including reduced recidivism and improved behavior.[68] County leaders decided to open a clinic focused on mental health treatment to further improve the services available to juveniles.

2. Medicaid Eligibility

Medicaid was crucial for Bernalillo's plan of improving juvenile mental health care and was necessary to open their mental health clinic.[69] It provided an essential means of funding for mental healthcare and lessened the burden of providing treatment which allowed for the creation and opening of the Youth Services Center.[70] In addition to its financial importance, Medicaid was also a way to increase the likelihood that youth

[64] JUVENILE DETENTION ALTERNATIVES INITIATIVE, THE ANNIE E. CASEY FOUND., A GUIDE TO JUVENILE DETENTION REFORM, BERNALILLO COUNTY MENTAL HEALTH CLINIC CASE STUDY 6–20 (2013).
[65] *Id.* at 17-18.
[66] *Id.* at 8.
[67] *Id.* at 9.
[68] *Id.*
[69] *Id.* at 11.
[70] *Id.*

receiving mental health treatment in detention facilities would continue to receive this treatment once they returned to the community.[71]

Originally, obtaining Medicaid for youth detained in Bernalillo was not immediately possible because of the aforementioned inmate exception. Leadership of Bernalillo met with New Mexico Medicaid officials to work on a policy change whereby youth in juvenile detention facilities were recognized as being in "temporary living arrangements[s]" rather than as "inmates of public institutions" for the first 60 days of detention or until the disposition hearing for their case,[72] whichever came first.[73] With approval from the federal regional Medicaid office, New Mexico Medicaid officials ultimately agreed to officially recognize placement in youth detention facilities as temporary living arrangements prior to trial.[74] This distinction allows Medicaid coverage to continue for juveniles in detention facilities while their cases are adjudicated.[75]

In addition to ensuring that youth in juvenile detention facilities can access Medicaid benefits, Bernalillo County also arranged, through a New Mexico Department of Human Services ruling, for juveniles entering either the detention facility or the Youth Services Center to receive "presumptive eligibility" to Medicaid.[76] New Mexico's presumptive eligibility allows easier, more immediate access to Medicaid through a simplified procedure that facilitates quicker access to care.[77] It also extends reimbursement for any care provided to youth from the date of entry into facilities, provided they are ultimately deemed Medicaid eligible.[78] Presumptive eligibility in New Mexico may be granted to youth under the age of 19 years whose families are below 235% of the federal poverty level.[79] The length of presumptive eligibility is up to 60 days from the date of the application.[80] With this in place, they can begin treatment immediately while undertaking the application process for eligible youth.[81] In addition to this facilitation of Medicaid access, the New Mexico Children, Youth, and Families Department employs regional coordinators who help juveniles obtain necessary documentation (such as birth certificates) to complete their Medicaid applications.[82] After ensuring that juveniles who entered the Youth Services Center would be eligible for Medicaid through presumptive eligibility and the temporary living arrangement designation, the clinic went through the process of becoming a "licensed, certified and

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[71] *Id.*
[72] *Id.* (citing New Mexico Department of Human Services Ruling 8.200.410.15 NMAC).
[73] *Id.*
[74] *Id.*
[75] *Id.* (citing 8.200.410.15 NMAC).
[76] *Id.*
[77] NAT'L CONFERENCE OF STATE LEGISLATURES, MEDICAID FOR JUVENILE JUSTICE-INVOLVED CHILDREN 9, *available at* www.ncsl.org/documents/cj/jjguidebook-medicaid.pdf.
[78] JUVENILE DETENTION ALTERNATIVES INITIATIVE, *supra* note 65, at 11.
[79] CARRIE HANLON, JENNIFER MAY, NEVA KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, A MULTI-AGENCY APPROACH TO USING MEDICAID TO MEET THE HEALTH NEEDS OF JUVENILE JUSTICE-INVOLVED YOUTH 12 (2008), *available at* http://www.nashp.org/sites/default/files/Multi_Agency_NASHP.pdf.
[80] *Id.*
[81] JUVENILE DETENTION ALTERNATIVES INITIATIVE, *supra* note 65, at 11; HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, *supra* note 80, at 11.
[82] HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, *supra* note 80, at 12.

credentialed Medicaid provider" in order to be able to receive Medicaid reimbursements.[83]

The next step was securing funding to build the clinic.[84] County leaders reached out to the three insurance companies that New Mexico hired to manage its Medicaid budget.[85] Known as managed care organizations, these insurance companies receive a lump sum from the state each year to reimburse Medicaid recipients for their medical expenses, including those for mental health treatment. At the end of each year, the companies keep any money not paid out in reimbursements as profits.[86] It was in these companies interest to ensure that services were provided as efficiently as possible because, by definition, they would become responsible for reimbursing juveniles in detention facilities who become presumptively eligible for Medicaid benefits.[87] County leaders convinced these companies that funding a clinic would ultimately save them money because the county could provide care at less cost than private providers. The companies together granted $74,000 and manpower to help begin the first year of the clinic.[88]

3. Benefits and Challenges

a. Costs

Despite their benefits, Medicaid reimbursements can only cover about one third of the Youth Services Center's costs in part because many of its clients are not eligible for Medicaid.[89] Medicaid funding is also not available for treatment individuals receive after 60 days of detention. It only reimburses for specific treatments and does not cover other costs associated with the clinic, including maintenance, security, and incidental expenses. Because of these deficiencies, the majority of the funding for the clinic comes from the budget of the detention center. [90] The outpatient clinic's budget in fiscal year 2010-2011 was $613,000. About $197,161 came from Medicaid reimbursements, $3276 from private insurance, and the rest, about $400,000, came from the county government's detention center budget.[91] Though this is a "substantial investment" for the juvenile detention facility, it will likely save money in the long-term as better services reduce recidivism rates lowering the population in the detention center and, subsequently, its expenses.[92]

b. Discharge Planning

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[83] JUVENILE DETENTION ALTERNATIVES INITIATIVE, *supra* note 65, at 11.
[84] *Id.* at 12.
[85] *Id.*
[86] *Id.*
[87] *See Id.*
[88] *Id.*
[89] Telephone Interview with Gerri Dupree, Juvenile Detention Alternatives Administrator at the Children, Youth, and Families Department of New Mexico, (Nov. 21, 2013).
[90] JUVENILE DETENTION ALTERNATIVES INIT., *supra* note 65, at 16.
[91] *Id.*
[92] *Id.*

Juveniles who are detained beyond the initial 60 days lose their Medicaid and must re-apply when released.[93] This makes it difficult to create effective discharge plans for youth who are released after 60 days, because there is no Medicaid funding for the pre-release assessments that they need.[94] Assessments require psychological professionals to evaluate progress and identify remaining problems to be addressed through community treatment. After 60 days, the costs of such assessments cannot be reimbursed through Medicaid, making them difficult to fund. New Mexico has arranged for several core service providers in the community to provide assessments pro bono.[95] Even with this arrangement, staff must work quickly once the youth have been released to ensure that there is no gap in treatment.[96]

c. Benefits

Several of the benefits of Bernalillo's on-site clinic structure include an increased ability for service providers to focus attention on youth involved in the juvenile justice system, an increased ability to emphasize attendance in treatment programs, and a better ability to facilitate continuity and easier transitions from the detention facility back into the community.[97] Bernalillo's leaders agree that the clinic has contributed to reducing the number of juveniles in detention centers in the long-term and has improved general outcomes for the youth involved.[98] The existence of the outpatient clinic reduces the length of stay in the detention center, alleviating judges' concerns about juveniles' inadequate access to mental health treatment.[99] The clinic also reduces the number of youth who have to be put into the detention facility, allowing juveniles to be more confidently placed, by probation agents, into alternative programs where they are guaranteed to receive quality mental health care.[100] In addition to reducing the number of youth in the facility, the Casey Foundation[101] reports that there was a 26% drop in juvenile crime in Bernalillo County in four years.[102]

4. Implementation in Mississippi

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[93] Telephone Interview with Gerri Dupree, Juvenile Detention Alternatives Administrator at the Children, Youth, and Families Department of New Mexico, (Nov. 21, 2013).
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] JUVENILE DETENTION ALTERNATIVES INITIATIVE, *supra* note 65, at 20.
[98] *Id.* at 17.
[99] *Id.* at 18.
[100] *Id.* at 17
[101] The Annie E. Casey Foundation describes itself as "a private charitable organization, dedicated to helping build better futures for disadvantaged children in the United States." Among other things, it dedicates resources to researching and publishing information on health and juvenile justice issues with the goal of helping underprivileged youth. THE ANNIE E. CASEY FOUND., THE CASEY FOUNDATION'S INVESTMENT IN JUVENILE JUSTICE, http://www.aecf.org (last visited Oct. 19, 2013).
[102] THE ANNIE E. CASEY FOUND., THE CASEY FOUNDATION'S INVESTMENT IN JUVENILE JUSTICE, http://www.aecf.org/Home/OurWork/JuvenileJustice/JuvenileJusticeOverview.aspx (last visited Oct. 11, 2013).

Creating a mental health clinic to supplement a juvenile detention facility may not be the most prudent approach (or a feasible option) in every state[103] and there are various hurdles to this approach. The first, obvious hurdle is Medicaid. As the Bernalillo County example illustrates, this sort of approach is only possible if the implementing organization works with the state's Medicaid officials to arrange access to Medicaid for youth in detention facilities.[104] Before Medicaid reimbursements are possible, there must be further cooperation with state Medicaid officials and managed care organizations to certify the clinic as a qualified Medicaid provider.[105] Another hurdle may be cost. The cost of implementation of a program like that of Bernalillo County is significant.[106] Even with Medicaid reimbursements acting as a supplement, there are still substantial costs of running such a clinic that must be provided through some state budgetary avenue.[107]

Even if Mississippi cannot create a clinic, it can still minimize the effects of the inmate exception by classifying juvenile detention for fewer than 60 days as temporary living arrangement rather than incarceration, in order to receive Medicaid funding for mental health treatment provided to these juveniles. Specifically, Medicaid will reimburse psychiatric assessments, individual and group therapy, psychotropic medications, and professional visits from psychiatrists. Mississippi can also use Bernalillo's strategy of reaching out to community care insurance companies for implementation assistance. Mississippi's Medicaid program contracts with Magnolia Health and United Healthcare to insure its Medicaid population.[108] These organizations may be interested in partnering with the state to provide services to children in the juvenile justice system in order to increase enrollment numbers and subsequent Medicaid reimbursements.

B. Louisiana

The need to improve access through Medicaid services for juveniles arrested can be seen in Jefferson Paris, Louisiana, where state officials approximate that 79% of juveniles who are arrested receive services through Medicaid or the State Children's Health Insurance Program.[109] In Louisiana, the focus has been on reforming three areas in juvenile services: "expanding alternatives to formal process and secure confinement, increasing access to evidence-based services, and reducing disproportionate minority contact with the juvenile justice system."[110]

1. Increased Communication between Governments and Stakeholders

[103] JUVENILE DETENTION ALTERNATIVES INIT., *supra* note 65, at 23.
[104] *See Id.* at 11.
[105] *See Id.* at 12.
[106] *See Id.*
[107] *See Id.*
[108] MISS. DIV. OF MEDICAID, MISS. COORDINATED ACCESS NETWORK, https://www.medicaid.ms.gov/mscan/Welcome.aspx (last visited January 15, 2014).
[109] HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, *supra* note 80, at 4.
[110] *Id.* at 5.

Louisiana worked to accomplish these goals through a multi-stakeholder process that connects officials from local and state government, as well as different agencies, to each other.[111] These officials, including lawyers, representatives from the school system, and judges, convene in each judicial district to form "children and youth planning boards."[112] These planning boards are responsible for recognizing "gaps" in the services provided to children with social, emotional or developmental problems by local providers.[113] Subsequently, the planning boards transmit their conclusions and recommendations, informed by developments in the local communities, to the state level, where these recommendations are taken into account when determining the budget for mental health and juvenile justice facilities.[114]

2. The Juvenile Justice Implementation Commission

In 2003, the Louisiana legislature passed the Juvenile Justice Reform Act, which sought to accomplish many of these goals and embodied many of the same processes used by the planning boards, including connecting state and local governments and agencies to facilitate communication and evaluation of services. The law also sought to increase coordination between agencies that work with youth involved in the juvenile justice system.[115] Part of the reform directed government agencies to build a robust collective data sharing system mandated through interagency agreements with one another.[116] In addition to this data collection and monitoring, the legislation created a Juvenile Justice Implementation Commission (JJIC) to coordinate and keep a record of systemic reform efforts. For example, the JJIC is coordinating a plan for the incorporation of extant state departments into a single state agency that will more efficiently administer the state's juvenile justice system.[117]

The JJIC, composed of six members, including a judge, a state senator, and an academic, among others, convenes regularly to bring together key actors in juvenile justice reform.[118] During these meetings, the JJIC elicits testimony from responsible stakeholders who must explain their decisions and evaluate subsequent outcomes.[119] As part of the JJIC's mission to both identify and recommend improvements for specific problem areas, the Commission has played a central role in evaluating juvenile housing facilities and researching different options to replace secure incarceration.[120] Finally, the Juvenile Justice Reform Act of 2003 reestablished the Children's Cabinet, an advisory

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[111] *Id.* at 11.
[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] *Id.* at 16.
[116] *Id.*
[117] *Id.*
[118] STATE OF LOUISIANA JUVENILE JUSTICE INITIATIVE: ISSUES AND REFORM, JUVENILE JUSTICE IMPLEMENTATION COMM'N, http://www.louisianajuvenilejustice.la.gov/index.cfm?md=misc&tmp=aboutCommiss (last visited Oct. 19, 2013).
[119] *Id.*
[120] *Id.*

group of which helps harmonize statewide programs for children with an especial emphasis on issues related to juvenile justice.[121]

3. Express Lane Medicaid Eligibility

As part of some states' efforts to "streamline data collection," states have sought to limit the amount of data that children and their families must give to state programs.[122] This simple, yet powerful reform has the added benefit of helping all families applying to Medicaid.[123] In Louisiana, as well as several other states, the "Express Lane Eligibility Option" enables Medicaid and other state health agencies (i.e. CHIP) to use data that state governments already possess from other programs, including income tax filings, to determine if someone qualifies for the program in question.[124] A popular method of implementing this "Express Lane Eligibility Option," includes the use of administrative renewals, through which income confirmation is completed using information collected by other state systems.[125] This process enables juveniles to get faster access to Medicaid benefits and subsequent mental health treatment. In January 2008, 1,007,188 people were covered by Louisiana's Medicaid and State Children's Health Insurance Program (SCHIP), which is an expansion of the Medicaid Program.[126] For fiscal year 2005, Louisiana spent an estimated $5.3 billion for Medicaid and $126 million on SCHIP services. (Seventy=one percent of the funding for Medicaid and 80% of the funding for SCHIP was provided by the federal government).[127]

Agency and community stakeholders interviewed for a recent report on efforts to coordinate different kind of services impacting youth cited the Juvenile Justice Reform Act of 2003 "as an impetus for change and believe it promotes shared responsibility among key agencies for improving the welfare of juvenile-justice involved youth."[128] Furthermore, as a result of the multi-state agency task force in Louisiana, the JJIC, evidence-based practices have been included in the state's plan of services covered by Medicaid.[129]

The benefits of these different types of strategies have gone beyond simply improving access to Medicaid. Additional benefits and outcomes have included coverage for previously un-covered therapies (e.g. Multi-Systemic Therapy) and early identification services, which can be helpful to achieve the goals of the juvenile justice system to expand alternatives to formal processing and secure confinement, increase access to evidence-based services, and reduce disproportionate minority contact with

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[121] *Id.*
[122] NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 78, at 9.
[123] *Id.*
[124] *Id.*
[125] *Id.*
[126] MELANIE GLASCOCK & CARRIE HANLON, NAT'L ACAD. OF STATE HEALTH POLICY, FACT SHEET: LOUISIANA MEDICAID AND SCHIP PROGRAMS 1 (August, 2008), *available at* http://www.nashp.org/sites/default/files/Louisiana_FactSheet.pdf.
[127] *Id*.
[128] HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, *supra* note 80, at 16.
[129] *Id.* at 14

the juvenile justice system.[130] These strategies have also led to greater continuity for children who maintain treatment providers as they move between systems. They have similarly led to incorporation of treatment concerns into the juvenile justice system as court case managers and staff become involved in the development of juvenile care plans.[131]

C. Other Innovations

1. Institute Evidence-Based Practices

Evidence-based practices (EBP) are treatments that are based on quantitative research that demonstrate effective outcomes in specific settings. For example, an evidence-based treatment in the juvenile justice system might be one that has been shown to reduce recidivism or improve objective mental health measures. EBPs treat the underlying problems that contribute to delinquent behavior and in doing so prevent contact with the justice system, reduce recidivism, and improve the lives of young people. For example, Ohio's investment in community care and treatment yielded from $11 to $45 return on the dollar depending on an individual youth's risk of recidivism.[132] In 2002, a national panel of experts recommended five EBPs for the mental health evaluation of youth involved in the juvenile justice system: (1) perform a valid and reliable mental health screen within 24 hours of admission; (2) perform a more extensive assessment by a mental health professional as soon as possible to determine service needs; (3) use multiple sources of information (e.g., medical records, family reports) to determine needs; (4) screen detainees before their release into the community; and (5) repeat screens on a regular basis while detainees are in custody, to identify emergent problems.[133]

In 2003, Drug Strategies, a non-profit organization, convened a panel to make recommendations on substance abuse treatment for adolescents. The majority of evidence-based drug treatment programs, of those programs that could be potentially adopted by a detention center (i.e. 30 days or less), employed the 12-step approach, cognitive behavioral therapy, or both.[134] New York recently implemented a new program called Adolescent Portable Therapy, where therapists work with families of juveniles as they move through the justice system and into the community. The program uses family and cognitive behavioral therapy.[135] Cognitive behavioral therapy has been found in

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[130] *Id.* at 5.
[131] *Id.* at 14.
[132] CHRISTOPHER T. LOWENKAMP & EDWARD J. LATESSA, EVALUATION OF OHIO'S RECLAIM FUNDED PROGRAMS, COMMUNITY CORRECTIONAL FACILITIES, AND DYS FACILITIES: COST-BENEFIT ANALYSIS SUPPLEMENTAL REPORT, UNIVERSITY OF CINCINNATI DIV. OF CRIMINAL JUSTICE (November 3, 2005).
[133] Wasserman GA, Jensen PJ, Ko SJ, et al., *Mental Health Assessments in Juvenile Justice: Report on The Consensus Conference*, 42 J AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 752–61 (2003).
[134] Brannigan, Rosalind, Schackman, Bruce R., Falco, Mathea, Millman, Robert B.,*The Quality of highly Regarded Adolescent Substance Abuse Treatment Progams: Results of an In-depth National Survey,* 158 ARCH. PEDIATR. ADOLESC. MED. 904-9, 906 (2004)(see Table 1).
[135] VERA INSTITUTE OF JUSTICE, ADOLESCENT PORTABLE THERAPY: A PRACTICAL GUIDE FOR SERVICE PROVIDERS, *available at* http://www.vera.org/publication-pdf/272-529.pdf.

meta-analyses to have positive outcomes in juvenile justice populations for violence and recidivism[136] as well as life skills generally.[137]

Finally, Washington is expanding alternatives to formal processing and secure confinement as well as improving access to mental health services.[138] In 1997, the state legislature passed the Community Juvenile Accountability Act which funded EBPs in the juvenile court system. Counties across the state choose between treatment programs identified by the state as EBPs and juvenile courts then assign offenders to the program based on evaluation of risk factors related to school, employment, relationships, family, drug/alcohol use, mental health, anti-social attitudes, and skills.[139] As part of this effort, one program featured the King County Superior Court receiving matching funds from the state to do staff outreach and other activities to encourage youth enrollment in Medicaid systems in its juvenile justice system.[140] The state has also sought to increase collaboration among the different agencies of government around mental health services for children.[141]

Washington specifically invested in Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Aggression Replacement Training (ART), and Interagency Coordination. MST is a community-based treatment in which practitioners work with juveniles and their families at their homes rather than in institutions. Clinicians can then intervene directly into the systems that cause delinquent behavior such as parental discipline, family affective relations, peer associations, and school performance.[142] MST therapists have caseloads of four to six families and work in teams with one Ph.D. clinician and three or four clinicians with masters' degrees. This intervention is relatively expensive, costing $5,000 per family and is reserved for the highest risk offenders.[143] FFT is a family-based intervention that focuses on improving protective factors and reducing risk factors for juvenile delinquent behavior. It involves three stages: motivating the family toward change, teaching the family how to change a specific critical problem identified in the first phase, and developing general problem solving skills that the family can apply to future conflicts. FFT therapists maintain caseloads of 10-12 families who they visit approximately 12 times over a 90-day treatment period.[144] Finally ART helps juveniles develop skills to control anger and use appropriate behavior. It involves repetitive learning techniques and guided group discussion to correct anti-social thinking.

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[136] LIPSEY MW, WILSON DB, COTHERN L, EFFECTIVE INTERVENTION FOR SERIOUS JUVENILE OFFENDERS, WASHINGTON, DC: OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION 1-8 (2000).

[137] Roush DD, Roush DW, *Holistic Environmental Life-Skills Project (HELP): A Public-Private Partnership to Provide Helpful Services to Youth in a Juvenile Detention Facility,* 17 JUVENILE JUSTICE DIGEST 4–6 (1993).

[138] HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, *supra* note 80, at 5.

[139] WASHINGTON STATE INST. FOR PUBLIC POLICY, OUTCOME EVALUATION OF WASHINGTON STATE'S RESEARCH-BASED PROGRAMS FOR JUVENILE OFFENDERS 4 (Jan. 2004).

[140] HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, *supra* note 80, at 11.

[141] *Id.* at 16.

[142] Henggeler, Scott W., Melton, Gary B., Smith, Linda A., *Family Preservation Using Multisystemic Therapy: An Effective Alternative to Incarcerating Serious Juvenile Offenders*, 60 J. CONSULTING AND CLINICAL PSYCHOLOGY 953 (1992).

[143] WASHINGTON STATE INST. FOR PUBLIC POLICY, *supra* note 140, at 13.

[144] *Id.* at 5.

Therapists administer ART over 10 weeks to groups of 8-12 juveniles three times per week.[145]

All three of these treatments reduced recidivism over the 4-year period during which they were studied.[146] Specifically, when FFT is delivered competently, it reduces felony recidivism by 38%, saving $10.69 for each dollar spent on the program. It saves $2.77 per dollar regardless of therapist competence.[147] ART reduced recidivism by 24%, resulting in $11.66 savings for every dollar spent.[148]

2. Improve Community-Based Alternatives

One method that states have used to improve mental health treatment for youth in the juvenile justice system is to take advantage of community-based alternatives. In Illinois, the state is attempting to develop "community-based alternatives to secure confinement" and treating young people involved with the juvenile justice system.[149] Redeploy Illinois is a state government program that financially supports counties in efforts to provide youth who might otherwise be sent to the juvenile justice system with comprehensive treatment in the community.[150] Over the past three years, 700 youth have been diverted to community treatment through the program. 14.2% of Redeploy recipients were re-incarcerated after completing the program, as compared to 57.4% of those sent to juvenile detention.[151]

Missouri has altered its detention facilities to resemble community-based treatment as much as possible. This approach has seen recent success in reducing recidivism rates, while maintaining a strong safety record and better outcomes on a modest budget. Missouri has attempted to reduce the size of treatment facilities for troubled youth, providing them smaller, more familial group homes, rather than large, prison-like facilities.[152] Whereas most youth confined in state juvenile correctional facilities are housed in institutions with more than 150 beds, the largest in Missouri has 50.[153] There is little security hardware. Walls are adorned with bulletin boards displaying residents' art and papers.

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[145] *Id.* at 9.
[146] NAT'L COUNCIL OF STATE LEGISLATURES, JUVENILE JUSTICE GUIDEBOOK FOR LEGISLATORS, COST BENEFIT ANALYSIS OF JUVENILE JUSTICE PROGRAMS 4, *available at* http://www.ncsl.org/documents/cj/jjguidebook-costbenefit.pdf.
[147] WASHINGTON STATE INST. FOR PUBLIC POLICY, *supra* note 140, at 1.
[148] *Id.*
[149] HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, *supra* note 80, at 5.
[150] CLARKE, ELIZABETH E, SHIFTING AWAY FROM INCARCERATION: FISCAL REALIGNMENT STRATEGIES TO END THE MASS INCARCERATION OF YOUTH IN THE UNITED STATES, INTERNATIONAL JUVENILE JUSTICE OBSERVATORY CONFERENCE PRESENTATION PROPOSAL, JUVENILE JUSTICE INITIATIVE 5 (2012), *available at* http://www.njjn.org/uploads/digital-library/IJJO_FINAL_PAPER-Conference_Workshop_proposal_Betsy-Clarke_4-30-12.pdf.
[151] *Id.*
[152] THE MISSOURI MODEL: REINVENTING THE PRACTICE OF REHABILITATING YOUTHFUL OFFENDERS, THE ANNIE E. CASEY FOUND., 5 (2010), *available at* http://www.aecf.org/~/media/Pubs/Initiatives/Juvenile%20Detention%20Alternatives%20Initiative/MOModel/MO_Fullreport_webfinal.pdf.
[153] *Id.* at 15.

Rather than confining youth in cells, Missouri places them into small groups, offering extensive attention.[154] Missouri offers youth development programs by youth development specialists rather than correctional supervision by guards.[155] Low-risk youth with limited juvenile records are often sent to one of seven non-secure group homes in the state, where they attend school and spend time working jobs and doing group activities.[156] There are also moderate secure and secure facilities for greater offenders, which involve less time spent outside of the facility. Despite this general progress, Missouri has failed to offer individual psychotherapy for youth with identified mental health problems.[157] However, residents do participate in family therapy toward the end of their stay.

3. Support Post-Detention Transitions

Improving services that assist juveniles in their transition from detention to the community is another method for improving mental health treatment of juveniles in the justice system because those who effectively transition into community treatment programs are less likely to return to the juvenile justice system. Pennsylvania has improved the quality of its support for youth transitioning out of detention and into the community by assisting them in locating and obtaining services.[158] To help accomplish these goals, Pennsylvania has improved the eligibility process for youth involved with the juvenile justice system though cross-agency relationships and tracking data about individuals.[159] The state created liaisons, which include probation offices, detention centers, and county assistance officers, who determine Medicaid eligibility, collaborate to refer transitioning youth to needed services and to inform the county assistance office about their whereabouts.[160] This system is reinforced by data that the state tracks and maintains on Medicaid eligibility.[161] Pennsylvania also implemented the Integrated Children's Services Planning (ICSP) Initiative in 2005, which requires each of the state's counties to submit annual plans for the integration of children's services.[162] The overall goal of ICSP is to create a comprehensive services system that efficiently meets all of a child's needs including mental health, physical health, education, and welfare.[163] The state saved $317 million by investing in treatment programs. Some of the programs, including Life Skills Training yielded $25.72 in savings for every $1 spent.[164]

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[154] *Id.* at 2.
[155] *Id.*
[156] *Id.* at 16.
[157] *Id.* at 20.
[158] HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, note 80, at 13.
[159] *Id.*
[160] *Id.*
[161] *Id.*
[162] *Id.* at 14-15.
[163] *Id.* at 14-15.
[164] NAT'L COUNCIL OF STATE LEGISLATURES, *supra* note 147, at 4.

4. Reduce the Population in Detention Facilities

There is some concern that juvenile detention centers' improved mental health services are driving their current overpopulation problem, crowding out a viable juvenile mental health system outside of incarceration .[165] When unable to find treatment elsewhere, detention centers become attractive for family members of mentally ill minors, sometimes seeking out detention in order to ensure access to treatment. [166] With no readily-available, affordable community options, children's mental problems go untreated, worsen, and eventually land them in the juvenile justice system.

One way to address this problem is to sever the link between community services and detention treatment services. Specifically, community-based treatments should not require detention for initial bad behavior. This "no detention" element makes these options affordable.[167] Some states have adopted "mental health courts" for juveniles with serious mental health problems as a way to organize treatment without incarceration.[168]

Another way to address this problem is to prohibit juvenile detention as a punishment for non-violent offenses. Many youth in the juvenile system are there for nonviolent offenses. In 2003, over 75% of Louisiana's youth detention population was incarcerated for nonviolent drug offenses.[169] In recent years, a number of states (including Alabama, California, New York, North Carolina, Ohio, and Texas) and localities (including Chicago, Detroit, and Santa Cruz) have tried to screen out youth who pose a minimal threat to public safety.[170] Following this, these jurisdictions actually all had lower youth crime rates and saved public funds in the process. In Santa Cruz during the 1990s, a juvenile hall averaged 50-60 youth. Now they average 20, and 90% have not committed new crimes within three years. The reduction in expenditures on minor offenders can be reallocated to provide better mental health treatment for more serious offenders.

Reducing the population in detention will also enable Mississippi to utilize Medicaid funding. Mississippi can divert juveniles away from public detentions in favor of intermediate options. For example, a juvenile who receives pre-trial probation can be required to participate in outpatient treatment provided at a community mental health center. Medicaid will reimburse this treatment, including individual and group therapy as well as medication management. Juveniles can also be placed under house arrest and visited by psychiatric professionals whose services will be reimbursed through Medicaid. Finally they can be sent to small group homes that specialize in treatment and public

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[165] See Thomas Grisso, *Progress and Perils in the Juvenile Justice and Mental Health Movement*, 35 J. AM. ACAD. Psychiatry Law 158, 164 (2007), *available at* http://www.jaapl.org/content/35/2/158.full.

[166] *Id.*

[167] Patrick Geary, *Juvenile Mental Health Courts and Therapeutic Jurisprudence: Facing the Challenges Posed by Youth with Mental Disabilities in the Juvenile Justice System*, 5 Yale J. Health Pol'y, L. & Ethics 671 (2005).

[168] Loresha Wilson, *Mental Health Court Keeps Kids out of Jail*, SHREVEPORT TIMES (2010), *available at* http://www.houmatoday.com/article/20100215/ARTICLES/100219757?p=1&tc=pg.

[169] SKOWYRA, KATHLEEN & JOSEPH COCOZZA. BLUEPRINT FOR CHANGE: A COMPREHENSIVE MODEL FOR IDENTIFICATION AND TREATMENT OF YOUTH WITH MENTAL HEALTH NEEDS IN CONTACT WITH THE JUVENILE JUSTICE SYSTEM. THE NAT'L CTR. FOR MENTAL HEALTH AND JUVENILE JUSTICE 1 (2007).

[170] THE MISSOURI MODEL: REINVENTING THE PRACTICE OF REHABILITATING YOUTHFUL OFFENDERS, *supra* note 153, at 5.

institutions with fewer than 16 beds; however this is not a viable option, considering the fact that the Department of Mental Health does not operate an inpatient facility with so few beds.[171]

5. Improve Communication and Collaboration Between Agencies

Most of the innovations that these other states have implemented involve two key concepts: improving collaboration among different government agencies at different levels (both local and state) and improving data collection and data sharing across these agencies. Both of these strategies serve to not only help those youth involved within the justice system but also all children who qualify for services that the state offers.

For example, the children and youth planning boards in Louisiana, which require relatively little new infrastructure, can help coordinate and focus action towards improving services for juveniles and are relatively cheap to implement. In particular, the "Express Lane Eligibility Option" does not require much new infrastructure or funding, but rather allows different agencies to utilize data that has already been collected through other programs. Similarly Illinois also created the Bureau of Interagency Coordination (BIC) in 1999, which serves as the main contact in the Medicaid department for numerous agencies that deliver services to persons enrolled in state medical programs.[172] The BIC not only works with agencies within the Department of Health Services but also with the University of Illinois Division of Specialized Care for Children, among others, and has built a statewide structure that enables data sharing and communication between the different counties enrolled in the Medicaid Matching Fund program and Medicaid.[173]

Increased collaboration and data sharing can provide significant benefits. For example, data that indicates that a particular juvenile needs mental health services and/or qualifies for Medicaid can be used by courts to identify offenders who might benefit from a diversion program. Alternatively, courts can communicate with detention facilities to alert them to the needs of the juvenile before they enter detention, improving the efficiency of such services. Outside of the courtroom, increased communication between state and local actors can improve early identification of high-risk youth in schools and other community settings and subsequent interventions. This intervention can help prevent troubled youth from ever entering the justice system. As fewer individuals enter detention facilities, there are more resources for the youth who are detained. Mississippi has already taken steps to improve communication between different actors through the creation of a task force to assess mental health treatment in juvenile detention that has identified many of these problems. It can continue to improve communication by creating a data sharing system that includes local courts, Medicaid offices, and the Departments of Mental Health, Corrections, and Children and Family Services. Such sharing would enable it to create express lane eligibility for Medicaid services.

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[171] DIV. OF YOUTH CHILDREN & YOUTH SERVICES DIRECTORY, MISS. DEP'T OF MENTAL HEALTH 35 (2012), *available at* http://www.dmh.state.ms.us/pdf/CYS%20Directory%20-%206-4-12.pdf.
[172] HANLON, MAY, KAYE, NAT'L ACADEMY FOR STATE HEALTH POLICY, *supra* note 80, at 4.
[173] *Id*. at 5.

III. Conclusion

Mississippi spends close to $100,000 per day housing juveniles in overcrowded, under-resourced detention facilities.[174] Although the majority of these children suffer from a diagnosable mental illness, these facilities do not provide adequate mental health treatment. These deficiencies contribute to recidivism as the underlying causes of delinquent behavior are ignored. Furthermore, by incarcerating juveniles rather than providing services in the community, Mississippi foregoes significant federal Medicaid subsidies due to the "inmate exception."

Mississippi has the opportunity to strengthen its juvenile justice system by investing in mental health and substance abuse treatment for its juvenile offenders. Several other states and counties provide workable models for Mississippi to follow. These models generally incorporate one or more of the following components: strengthening alternative placement options, focusing investments on evidence-based treatment practices, reducing the population in juvenile detention centers, and increasing collaboration between relevant government agencies. All of these components increase availability of Medicaid funding, which would particularly benefit Mississippi, as the Federal government contributes the majority of Medicaid reimbursements in this state.

Examples of effective state and county models include Bernalillo County in New Mexico, which opened a pre-adjudicative residential clinic jointly funded by the county and Medicaid reimbursement to provide an alternative, treatment centered placement for juveniles. Louisiana developed an infrastructure by which state and local actors could communicate and coordinate juvenile justice reform. Key components of this reform included a system to expedite Medicaid eligibility determinations, and elimination of detention facilities as a punishment option for non-violent crime. Washington focused funding on treatments proven to reduce recidivism including MST, FFT, and ART. Finally, Missouri closed larger detention facilities in favor of small residential facilities in which resources could better target the needs of individual youth.

Mental health treatment is not only beneficial for those who receive it, but also extremely cost effective. Investments in evidence-based, community treatments have yielded saving's returns as high as 45:1.[175] Even lower investment returns represent enormous long-term savings for the state. These savings stem from reduction in reliance on expensive detention facilities, reduced recidivism and increased subsequent productivity, and increased ability to utilize Medicaid funding by avoiding the "inmate exception." Mississippi has an incredible opportunity to improve the lives of its citizens, while saving money, by investing in mental health and substance abuse treatment in its juvenile justice system.

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[174] JUSTICE POLICY INSTITUTE, THE COSTS OF CONFINEMENT: WHY GOOD JUVENILE JUSTICE POLICIES MAKE GOOD FISCAL SENSE 4 (2009).

[175] WASHINGTON STATE INST. FOR PUBLIC POLICY, *supra* note 140, at 1.