NATIONAL ACADEMY
for STATE HEALTH POLICY

Meeting the Health Needs of Youth Involved in the Juvenile Justice System

Karen Clark
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September 2006

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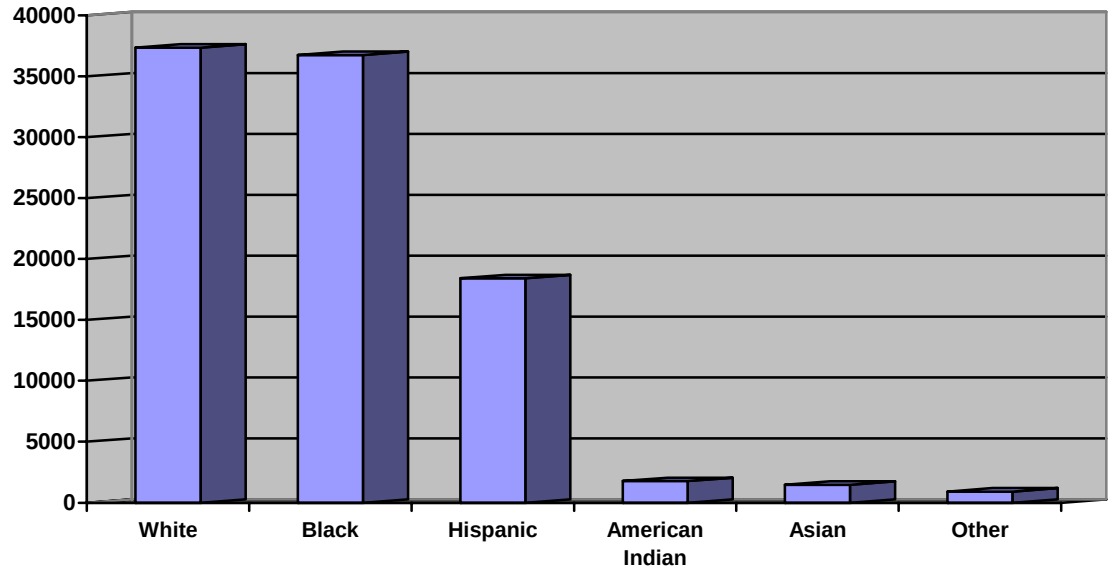
HEALTH AND JUVENILE JUSTICE

Nearly 100,000[1] young people are in juvenile justice facilities of some sort on any given day, with more than 2 million arrested in a year.[2] Of those in residential settings, 62 percent are minorities, 85 percent are boys, and many, if not most, lack adequate health insurance coverage.[3] Youth in juvenile justice facilities – including detention centers, shelters, diagnostic centers, group homes, wilderness programs, residential treatment facilities and training schools (where most juveniles are committed) – suffer disproportionately from a host of mental and physical health problems. The presence and severity of health problems may help explain the behaviors that led to their involvement in the criminal justice system and make it critical they receive the appropriate medical services both in the system and upon their release.[4]

Most of those arrested do not end up at trial. Of those who are tried, about two-thirds are sentenced to probation after a trial,[5] allowing a true opportunity for therapeutic intervention in the community. Given the preponderance of low-income youth involved with the juvenile justice system, it is likely that many who enter are enrolled in or eligible for Medicaid.

States and local governments face stiff challenges in organizing and funding services for troubled youth. One challenge is to make Medicaid work better for this population during those times an individual is not in a public institution. Another challenge is to ensure that quality and effective services are provided to individuals both during and after their involvement in the juvenile justice system. Medicaid presents unique limits and opportunities compared to state and local funding. Services provided to those involved in the juvenile justice system are impacted by these funding matters. This paper describes these limits and opportunities, and highlights a number of promising practices and service models in states.

Figure 1 Census of juveniles in residential placement by race/ethnicity 2003



Source: Census of Juveniles in Residential Placement Databook, 2004

A variety of health issues are demonstrated in the juvenile justice population. The ones that cause the most concern are those that affect behavior, such as substance use disorders, mental illnesses and conditions, and untreated oral health problems.[6]

According to the American Medical Association, Council on Scientific Affairs: "Youth who are detained or incarcerated in correctional facilities represent a medically undeserved population that is at high risk for a variety of medical and emotional disorders. These youth not only have a substantial number of pre-existing health problems, they also develop acute problems that are associated with their arrest and with the environment of the correctional facility... Indicative of both their personal behavior and their lack of adequate prior health care services, youth in correctional institutions have a greater than expected rate of selected physical and emotional problems, such as substance abuse, sexually transmitted diseases, unplanned pregnancies, and psychiatric disorders."[7]

Oral Health

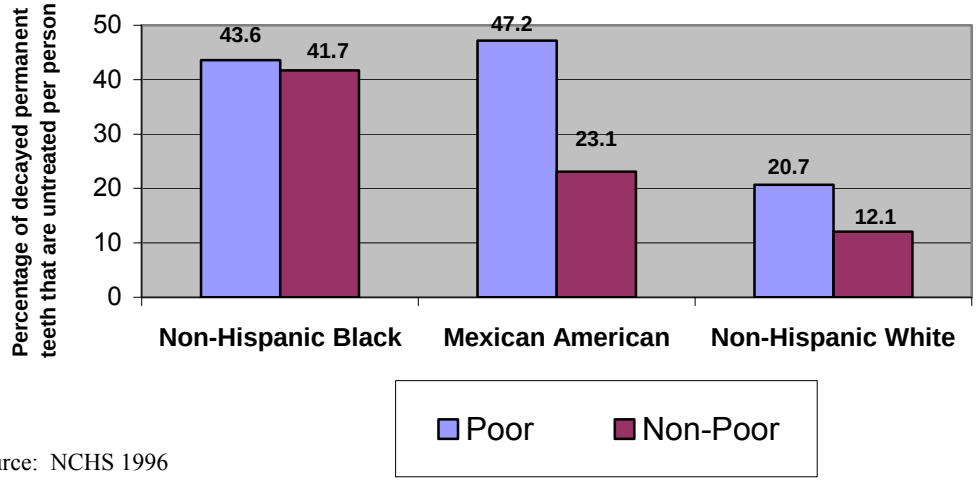
The oral health of the juvenile population is a serious problem that has received much less attention than other health problems by researchers and program administrators.

Tooth decay is the most common chronic disease among children in America. Children from families who earn less than 200 percent of the federal poverty level – which are overrepresented in the juvenile justice population – are three times as likely to have

unmet dental care needs than those from higher income families. Only about one-third of poor children see a dentist in any given year, compared to 71 percent of higher income children.[8] Minority children are much less likely than white children to see a dentist. As determined in a study performed by the National Health Service Corps in 1996, "poor adolescents ages 12 to 17 in each racial/ethnic group have a higher percentage of untreated, decayed permanent teeth than the corresponding non-poor adolescent group"[9] (See Figure 2). Although there is no national data on prevalence, a survey in Washington state found that dental problems were reported in 65.9 percent of youth involved in its juvenile justice system.[10] Because untreated oral health problems affect the ability to eat, learn, sleep, form healthy self-esteem, and interact with peers and adults, they can substantially impact young people's behavior. These unmet needs are likely to tax the juvenile justice system as well.

"Although dental problems don't command the instant fears associated with low birth weight, fetal death, or cholera, they do have the consequence of wearing down the stamina of children and defeating their ambitions. Bleeding gums, impacted teeth, and rotting teeth are routine matters for the children I have interviewed in the South Bronx. Children get used to feeling constant pain. They go to sleep with it. They go to school with it. Sometimes their teachers are alarmed and try to get them to a clinic. But it's all so slow and heavily encumbered with red tape and waiting lists and missing, lost, or canceled welfare cards, that dental care is often long delayed. Children live for months with pain that grown-ups would find unendurable. The gradual attrition of accepted pain erodes their energy and aspiration. I have seen children in New York with teeth that look like brownish, broken sticks. I have also seen teenagers who were missing half their teeth." Jonathan Kozol, , *Savage Inequalities: Children in America's Schools. (Crown Publishers, 1991.)*

Figure 2 Poor Children aged 12 to 17 in each racial/ethnic group have a higher percentage of untreated decayed permenant teeth than non-poor children



Source: NCHS 1996

Substance Use Disorders

According to the National Center for Addiction and Substance Abuse (CASA) at Columbia University, addiction and substance use disorders affect a majority of the juvenile justice population: "Four of every five children and teens (78.4 percent) in juvenile justice systems – 1.9 million of 2.4 million arrests of 10 to 17-year olds – are under the influence of alcohol or drugs while committing their crime, test positive for drugs, are arrested for committing an alcohol or drug offense, admit having substance abuse and addiction problems, or share some combination of these characteristics."[11]

The prevalence of substance abuse among this population is rarely addressed. Substance abuse is a clinical disorder which requires an extended period of rigorous treatment. Such treatment has been shown to be effective. Research shows that juveniles with substance use disorders who received treatment were less likely to commit a drug-related crime in the year following admission to treatment.[12] Incarceration presents an opportunity to engage with juveniles who typically have little contact with or access to treatment services. This situation could help to provide them the structure and positive environment needed in order to succeed and begin recovery from this disease. Only about 3.6 percent of juveniles in the justice system receive treatment services (in any form).[13]

Mental Health

Almost as common, and often co-occurring with substance use disorders, are mental illnesses. Evidence suggests that more than 70 percent of juveniles involved in the system have a mental health and/or substance abuse disorder and that about one in five youth is plagued with a serious mental health problem.[14] These identified problems include, but are not limited to: attention-deficit/hyperactivity disorder, conduct disorder, post-traumatic stress disorder, oppositional-defiant disorder, and depression. This makes mental health services a necessary component for those high-risk juveniles involved in the system, both in and out of public institutions. Researchers have documented that those juveniles who do not receive appropriate, effective treatment after release are more likely to return to jail.[15] Unfortunately, the juvenile justice system is not well-equipped to handle mental health disorders. Though some cutting edge systems have been created by innovative state agencies, most juvenile justice services provided within public institutions lack adequate treatment services. One of the reasons for the gap is that the issue needs to be addressed among all state agencies that work with this population, not by the juvenile justice system alone. It is unreasonable to assume that juvenile justice systems, which specialize in public safety and confinement, should effectively determine and deliver the most appropriate mental and behavioral health services needed within institutional walls.

Who is Responsible?

Regrettably, most health and juvenile justice agencies within states have not worked together at addressing these issues. Many juveniles involved with the justice system are also involved in a number of public systems. They may be enrolled in Medicaid,

receiving special education services, in foster care, or working with a child protective services case manager. All of these agencies might play a small role in the ongoing treatment with a child, but agencies tend to shy away from accepting responsibility for total treatment of a child, usually due to budget constraints.

Without careful planning and coordination, the involvement of so many different entities can lead to inadequate treatment and uncoordinated or conflicting services. Lack of appropriate treatment not only allows for higher recidivism rates, but also causes many individuals to deliberately return to institutions where they were actually receiving some type of care for their health problems.[16] Furthermore, it has been determined that those individuals with mental health disorders who do not have access to treatment may suffer from a diminished capacity to respond to others (such as authority figures/police officers), and may experience a worsening of the mental health condition overall[17] which may lead to increased recidivism.

Recidivism

Simply put, recidivism is the repetition of criminal behavior. Some analyses count a re-arrest when determining recidivism, while others only count re-incarceration. It is very difficult to estimate the actual recidivism rate due to great differences among methods used by juvenile justice systems in each state. However, the Bureau of Justice Statistics states that 80 percent of youth under the age of 18 that were released from juvenile justice institutions in 1994 were re-arrested.[18] Though little research has been done to determine indicators of recidivism, a study in the Vermont State Department of Developmental and Mental Health Services found a strong correlation between juvenile incarceration rates and the utilization of public mental health services.[19] As reported by the Bazelon Center for Mental Health Law, The Performance Indicator Project in Vermont found that among 14 states, those with the highest public mental health service utilization rate had the lowest incarceration rate, while those with lower public mental health service utilization rates showed increased rates of incarceration.[20] This finding supports the claim that mental health services are essential for this population. Over the long term, providing mental health and other services could reduce repeat offenses and improve the lives of the children and families involved.

Ensuring that good quality treatment services for mental and physical health are offered in correctional institutions could have a positive impact on juveniles as they leave the facilities and return to their communities. The American Academy of Pediatrics (AAP) began in 1973 to address concerns regarding health care for those in correctional care facilities through policy statements which attempt to identify standards of care.[21] The AAP is not alone in its efforts to identify standards of care; it participates with more than 30 other organizations on the Board of the National Commission on Correctional Health Care (NCCHC). This organization focuses on improving the provision of health care in the criminal justice system by publishing national standards and position statements and offering a voluntary accreditation program.[22] Recently, the NCCHC adopted Clinical Guidelines intended to provide support to institutions in meeting the needs of juveniles who demonstrate some of the most common and problematic conditions identified. These

guidelines focus on "total disease management" and provide some guidance as to the barriers to treatment within the correctional institutions.[23]

National Commission on Correctional Health Care, Health Care Funding for Incarcerated Youth

NCCHC states in its position statement regarding health care and incarcerated youth: "America's future depends on the health of all of our children. Incarcerated youth represent an especially vulnerable population whose lives are at high risk for illness and disability. Early diagnosis and treatment is essential. The National Commission urges equality in access and funding for health care and, therefore, recommends that all youth in public and private confinement and detention facilities remain eligible for all public (e.g., Medicaid) and private health care coverage consistent with state and local eligibility requirements. All of America's youth deserve the opportunity for equal access to health care regardless of placement in public or private facilities."

While there is a great need for services for youth involved in the juvenile justice system, there is an equally great need that they be re-connected to services when they leave. Discharge planning and the process used to establish care in the community is a critical, but often neglected, part of the system. "First, any abrupt discontinuity in the care received while incarcerated puts the youth at significant risk for relapse. Second, many questions remain about the challenges to enrollment, eligibility for benefits, and identification of treatment facilities for youth release from juvenile justice facilities, and third, not only should the percentage of youth in the juvenile justice system with chronic illnesses be alarming, but the lack of services being received by this population should be of concern."[24]

The typical juvenile justice youth is a boy, a minority, low-income, has received inadequate health services, and has been diagnosed with a mental health disorder. This individual begins his involvement in the juvenile justice system with disadvantages, barriers, and needs. Some of these challenges are addressed within the justice system, but not adequately managed back in the community. The connection to appropriate services and managing the child's needs in the community is integral to his success after leaving state custody. One of the main financial support systems that would benefit most of these young people is Medicaid.

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MEDICAID

Health needs for juveniles are among the most important factors to consider upon re-entry. The lack of immediate re-connection to Medicaid upon release from a public institution (in some states), makes it more difficult for juveniles to access the services they need. Juveniles re-entering the community from a public institution face many barriers at the outset: stigma associated with incarceration, delays and missed material in education, and a stressed family environment among many others. Their ability to deal with these situations becomes more difficult if they are not able to manage their basic health issues.

As the public health care systems continue to change and costs of health care rise, accessing public health care is more and more difficult each day. Accessing services becomes even more difficult when involvement in the criminal justice system and lack of prior connection to services is a factor in determining availability of treatment. This is well-addressed by the Bazelon Center in an Issue Brief regarding access to federal benefits by inmates: "With long waiting lists, most community programs select people they believe can benefit quickly from services and those who will not pose particularly challenging problems for the program or engage in behaviors that disturb other clients. Lack of Medicaid coverage (despite possible eligibility) is an easy justification for denying access to such services."[25]

To further complicate the issues of access, there are clearly identified barriers that impact the services received by Medicaid enrollees. Enrollment in Medicaid does not guarantee access to services. Mental health, dental, and substance abuse services are often not available due to Medicaid state plan specifications regarding medical necessity and utilization review.[26] There are also common problems regarding low reimbursement rates and a limited supply of available participating providers, which lead to either long waiting lists or no care at all. These barriers can impact the provision of services, despite an individual's Medicaid eligibility.

Statute and Regulation

Medicaid is a joint federal- and state-funded medical assistance program administered at the state level. The federal government provides broad requirements within which states create their individual program. Federal code identifies services for which states can receive funding from the federal government at a pre-determined match rate, otherwise known as Federal Financial Participation (FFP). Federal Medicaid law prohibits FFP "with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)."[27] It does not state that inmates in public institutions are not eligible for Medicaid or that their Medicaid eligibility is lost once they become an inmate. A public institution does not include a medical institution, an intermediate care facility, a publicly operated community residence that services no more than 16 residents, or a child-care institution with respect to children receiving foster care or foster care payments.

In December 1997, the federal Department of Health and Human Services (DHHS) issued a letter to all regional Medicaid administrators that further clarified the statute and regulations. The most important clarification to note is that FFP should be available for children who have been sentenced to placement in a non-secure setting, and having been found "guilty" of a crime should not be a determining factor.[28] This clarification ensured that Medicaid funding was available for these children, as long as they were not placed in a public institution. The law was then further clarified in a separate letter regarding eligibility by defining that "states need not terminate Medicaid eligibility during an individual's period of incarceration."[29]

Suspension vs. Termination

Though federal Medicaid regulations do not require termination of the juvenile's Medicaid case and/or benefits, many states choose termination. States report that termination frequently occurs for one of the following reasons:

- Computer systems do not allow suspension; either the individual is deemed "Eligible" or "Not Eligible."
- The state has determined that the family the young person had when entering the juvenile justice system is different from the family he or she will join upon release, therefore creating eligibility problems upon re-entry.
- The state has determined that maintaining eligibility for those juveniles takes up too much staff time when the eligibility does not allow benefit access until the juvenile is released.
- The state has determined that when a case is terminated in the system, re-application is easily completed when needed.

Whatever the reason for terminating Medicaid eligibility upon entry into the juvenile justice system, such termination often results in an interruption in coverage for juveniles upon their re-entry into the community, partly due to the 45 to 90 days the average application takes to process.[30] Were the benefits suspended upon entry into the system, once the individual was released into the community, benefits could be accessed more quickly.

Another reason to suspend rather than terminate eligibility is to ensure that young people will receive prompt Medicaid coverage if they do become patients of a medical institution while they are incarcerated. This prevents the facility and/or youth from having to apply for Medicaid during a difficult time.

Presumptive Eligibility

One mechanism that has promise for ensuring that this vulnerable population receives services immediately, so no interruption in care occurs, is presumptive eligibility. This mechanism allows states to give health care providers and community organizations (referred to as "qualified providers") the authority to enroll individuals who appear eligible in the Medicaid program "presumptively" and to receive payment for services

rendered. Services will be funded either until the original application has been screened and enrollment granted, or one month after the end of the month in which presumptive eligibility began (whichever occurs first). This type of eligibility helps fill in the gaps in services during the time it takes for a Medicaid application to be processed. Potential state issues associated with presumptive eligibility include a large increase in enrollees (therefore increasing expenditures) and the situation where individuals are presumed eligible, then determined ineligible (therefore making the state 100 percent responsible for the costs associated with treatment provided).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT is a service that states are required to include in their Medicaid packages for children under the age of 21. Under federal law, a state must provide any service that is needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services" even if the state has chosen not to cover those services in its state plan.[31] In other words, a state can provide those services needed to resolve or improve any condition identified in the screening process, despite their state plan limits on the scope of services for a particular condition.

Access to Health Services

A delay in access to community treatment services can potentially undo any progress an individual makes while incarcerated.[32] As can be expected, many juveniles that require services but are not enrolled in Medicaid end up at the emergency room. According to a 2000 study, "1.5 million adolescents are forced to use emergency departments as their usual source of healthcare."[33] Though these juveniles do receive care in the emergency room, they don't receive adequate preventative care, nor does it effectively help the juveniles to address ongoing issues other than that which brought them in for care in the first place. Ensuring that juveniles are enrolled in Medicaid, and have a medical home or assigned physician who can address prevention issues and treat other maladies as they arise, makes it more likely that adequate, cost-effective, and preventative care are provided to the at-risk juvenile justice population.

At first glance, a brief interruption in health care coverage might not appear to be tragic. However, those youth identified with severe physical and mental health disorders (including schizophrenia, bipolar disorder, chemical dependence, and severe depression) need to be able to take their prescribed and medically necessary medications in order to remain stable and function well in the community.

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MAKING THE CONNECTION

There are a number of state and local initiatives that demonstrate creative ways to work within current federal guidelines and streamline systems to effectively connect the juvenile justice population to Medicaid and other services. Some agencies have chosen to help juveniles restore their benefits upon re-entry by assisting with applications prior to release. Others have trained juvenile correctional staff on Medicaid eligibility processes, which helps them screen youth for benefits before they leave. Still other agencies have made information and forms available to juveniles and their families and encouraged them to apply. Other innovations currently used only in the adult system also offer promising models for the juvenile system. Some of these models, as described in a Bazelon Center Issue Brief are described below. [34]

Albany, New York created an Options Committee to focus on service issues for persons with co-occurring mental health and substance abuse disorders. As a result of the committee's work, the following changes were made to help inmates in the county corrections facility:

- Social service staff meets with an inmate 45 days prior to release to complete Medicaid application.
- The Medicaid application is registered, and once it has been reviewed it is tagged for activation upon release.
- The jail provides sufficient medication to the individual to allow time for benefits to be obtained.
- Once released, the inmate must go to the local social services office with appropriate documentation.

Rensselaer County, New York negotiated an agreement with the head of the state Medicaid agency. This agreement includes:

- The jail staff is trained by social services staff on Medicaid eligibility rules and documentation requirements.
- Applications are completed prior to release and sent to the local social services agency. The application is reviewed, approved, and sent back to the inmate. The inmate uses the approved application to activate benefits upon release by taking it to the local social services office.
- The county provides transportation for former prisoners to see community-based providers after their release.

Lane County, Oregon has an agreement between the criminal justice system and the local social services office for the following:

- Application for Medicaid benefits can be done prior to release – jail staff assist in completing the applications and faxing them to local office.

- The Medicaid office "fast-tracks" the applications by processing them in one to two days.
- Temporary Medicaid cards are then faxed back to the jail to ensure that inmates have immediate access upon their release.

While these states have taken steps to reconnect adults who leave prison to Medicaid, a number of states can also be identified for their work with the juvenile justice population. Each of these states represents a different technique and approach for making connections between state and local agencies involved in working with the juvenile justice population. New York places mental health clinicians within the institutions to assist both juveniles and staff with treatment issues; Alaska offers one specific case manager for each juvenile throughout their involvement in the system to provide continuity; Wisconsin has created a wraparound program that has helped to keep juveniles out of institutions; and Texas has created a diversion program that helps to keep juveniles in the community while still receiving the services they need.

New York[35]

For more than 25 years, the Office of Mental Health (OMH) and the Office of Children and Family Services, Division of Rehabilitative Services (DRS) in the state of New York have worked together to improve services for youth involved in the juvenile justice system.

New York has been creative in using Medicaid and state funds to provide services. Medicaid can be used for those "involved" in the juvenile justice system, beginning at the time of arrest, throughout the court process, to the time of release from supervision at the local and state levels. The services provided range from basic outpatient treatment recommended by a mental health professional, to group homes, to placement in a therapeutic residential setting with 16 or fewer beds. Though Medicaid funding for services helps to cut the costs to the state, appropriate treatment for the identified problem is the key focus. To address this issue, DRS opened a number of smaller, non-secure facilities which can be funded by Medicaid or other federal/state funding sources.

The ability of OMH and DRS to work together has yielded some innovative programs, including a sex offender program and a program where mental health outpatient clinicians are stationed within the juvenile justice facilities throughout the state.

Juvenile Sex Offender Program

The sex offender program in New York, which boasts an overall recidivism rate of less than 1 percent, focuses on engaging the family in the treatment being provided to the juvenile offender. Clinical psychologists and social workers provide treatment and case managers work with the parents of the program enrollees. Their role is to ally with the family, engage the parents, and help the parents understand the treatments offered and

how to work with the juvenile and the case manager to ensure that treatment goals can be met.

> Parents of the juveniles involved in the sex offender program in New York are coached and supported by parent advocates. Frequently, juveniles are re-arrested and at times, re-incarcerated because of minor infractions ranging from repetitive curfew violations to positive drug screenings. In this program, the parent advocate works with the parent(s) on sharing what happens with the child in the home so that, long before an incident is a probation violation, it can be addressed. For example: a young man involved in the program has been complying with the rules. He goes to school, comes home on time, goes to work, tests negative for drugs and alcohol, checks in with his probation officer, and makes sure someone always knows where he is. His mother notices that the young man's schedule has changed, and he is coming home later every night. Lateness can be addressed through a "safety plan" in order to catch the problem before it becomes a minor offense which could be labeled a probation violation, and lead to re-incarceration.

The sex offender program has worked with about 700 juveniles in eight years. Prior to the implementation of this program, the average length of stay in juvenile justice institutions was about 22.3 months. With this program the average institutional stay was reduced to approximately 14.5 months. The average length of "active" treatment in the program is approximately eight months with continuing support and relapse prevention from the parent advocate and probation officer or aftercare worker for the duration of the period of probation or aftercare. The support and supervision of the juvenile from parent, clinician, and probation or aftercare worker has yielded results in New York. However, services offered to the parents, while critical to the success of the program, cannot be funded by Medicaid as treatment for the child. New York has funded these services separately because the parents need support and guidance while their children receive mental health treatment.

Mental Health Clinicians in Institutions

Twenty-six years ago, New York pioneered the approach to co-locate mental health providers in juvenile justice facilities. The program was designed by OMH and DRS to work with juveniles while they are in the public institutions to which they are committed. Up to 42 percent of the juveniles are identified at intake as in need of mental health treatment. To meet these needs, OMH has funded 72 mental health outpatient clinicians for the juvenile justice system, 50 of which are permanently stationed within juvenile justice institutions. The decision to permanently place OMH staff within the institutions was made due to the initial success of simply having the clinicians available to the juveniles. These permanently stationed workers are placed in units that are smaller in size (number of beds) and can offer individualized treatments through the on-site staff. DRS provides the direct care staff and OMH provides the clinical staff. If the juvenile justice system were considered a community, the majority of the clinical staff would be offering outpatient clinic services to the population while the 21 staff working in specialized units offer a higher level, more controlled, and supportive residential service and experience.

The key to this system is the treatment plan. Upon intake, an individualized plan for the juvenile is created and re-entry planning started. Re-entry is considered a very structured event. Clinicians ensure that the juveniles are linked to the necessary aftercare services and appointments are set. In addition, there is a plan created for staff to understand what each young person needs regarding direct care. Both mental health and security staff share this information and focus on meeting the needs of the juvenile and avoiding conflicting messages and directions from staff.

New York Mental Health Clinicians in Public Institutions

- Funded by the Office of Mental Health
- 72 mental health clinicians work within juvenile justice facilities
- 21 of the 72 mental health clinicians work full-time in 7 units, allowing for constant access to treatment professionals

Alaska[36]

The state of Alaska presents very different solutions to serving young offenders since major cities are far apart, and, having fewer resources, state agencies work together or are integrated. Alaska's unique model uses a single state executive department to administer services from the beginning to the end of a person's involvement in the juvenile justice system. Many states have services divided among state and local levels, which can lead to a lack of continuity and interruption of services as a juvenile travels between the two levels.

The central office is located within Alaska's Department of Health and Social Services (DHSS), in the Division of Juvenile Justice (DJJ). Within DJJ, there are 16 probation offices and eight juvenile correctional facilities. This high degree of integration makes it easier to address inter-agency problems because there is less of a hierarchy and fewer people who need to agree on changes or initiatives. This allows for rapid alterations to the system. One such need involved evaluating children in state custody for eligibility in Medicaid. After having trouble processing applications quickly, DHSS and DJJ identified a need for change. DHSS decided to dedicate specific eligibility workers to specialize in this population and ensure timelier processing.

Alaska's approach to providing health care for juveniles involved in the system is similar to that of other states. When juveniles are in DJJ custody but not placed in a public institution, they are screened for Medicaid eligibility by their case manager. If a juvenile is Medicaid enrolled, any treatment service needed will be obtained and reimbursement requested from Medicaid when appropriate. For those Medicaid-eligible juveniles in DJJ custody who are placed in a public institution, their Medicaid is suspended. For those juveniles eligible for Medicaid upon release from a public institution, application/re-application will be completed by the juvenile probation officer upon their release.

Alaska has been creative with its use of the Medicaid Disproportionate Share Hospital funds (DSH), traditionally given to hospitals that serve a higher than average number of Medicaid clients. Alaska has contracts with the providers that stipulate the funds be used only to serve children. This contract exists to assist the state in guaranteeing services to their institutionalized children, whether public or private, Medicaid-funded or not.

The Alaska DJJ is focused on restorative justice (repairing the harm caused by the criminal act) and thus has been creative with services, particularly in the number of community-based services offered. According to the National Center for Juvenile Justice, some juvenile probation officers are located in schools or at Boys and Girls Clubs. Juveniles on probation also have the option of receiving traditional educational and treatment services during non-traditional hours to give more flexibility.[37]

Even though Alaska attempts to adhere to restorative justice principles, some juveniles pose a risk to themselves or others and must be behind bars. Services for this population are not funded with Medicaid dollars, but once they are released from secure supervision, Medicaid and other federal/state funding can be used. Services for non-institutionalized juveniles include individual counseling, therapeutic foster care and intensive supervision, and medically supervised treatment in a residential setting. The providers are chosen from a list of approved providers in a directory shared with the Office of Children's Services. This same list of providers is used when determining services for the estimated 6,000 juveniles involved in the system annually. For those 6,000 juveniles, Alaska only has about 200 beds in public institutions, and only 85 percent of them are in use at any given time. This demonstrates the progress Alaska has made in front-loading services to this population and using institutionalization as a last resort.

Aside from front-loading services, Alaska has also been participating in the "Reclaiming Futures" initiative sponsored by the Robert Wood Johnson Foundation. This initiative "promotes new opportunities and standards of care in juvenile justice by bringing communities together to improve drug and alcohol treatment, expand and coordinate services, and find jobs and volunteer work for young people in trouble with the law."[38] This initiative focuses on teenagers ages 13-17 who are arrested two or more times and are representative of the ethnic diversity in the juvenile justice population. Through this initiative; Alaska has created a multi-disciplinary case management team to ensure that all needs are addressed, has assisted in the creation of both the Anchorage Youth Development Coalition as well as a local Assessment Center; and plans to strengthen its information system allowing for common screening, tracking, and case review. All of these changes, according to Jeffrey A. Butts, research fellow with the University of Chicago and member of the Reclaiming Futures evaluation team, have allowed the communities to significantly improve "coordination of juvenile justice and substance abuse treatment services."[39]

For the future, Alaska is looking into accessing Medicaid funds for targeted case management (TCM) services. Though case management services are offered to all, the particular rules associated with claiming TCM funds through Medicaid are so rigorous and administratively cumbersome that it is sometimes more effective to use all state

funds. However, Alaska is exploring how to use TCM to improve both the quality of care provided, and the amount of Medicaid dollars that is brought into the state.

Wisconsin[40]

Diverting juveniles from the institutional setting and providing services in the community are strategies used by Wisconsin in working with the juvenile justice population. Keeping juveniles out of institutions not only helps to ensure the community connection and quality treatment, but also allows for the use of Medicaid-funded services when appropriate. The state helps to increase juvenile enrollment in Medicaid by using its technologically advanced system and helping agencies work together.

Wisconsin terminates the Medicaid cases of juveniles entering an institution because it has proven to be difficult and time-consuming for eligibility staff to track the frequent changes in a child's family system. The state has an updated computer system that allows for a hassle-free re-application once a juvenile is already in the Medicaid information system. Correctional staff who have been trained by eligibility staff complete this re-application, initiating the process prior to the person's release so that eligibility determination is complete and Medicaid services can be used to pay for services as needed.

Wisconsin has also started down the path of attempting to keep juveniles out of the institutions and serving them in the community. There are many sentencing options available, including the traditional short-term detention (usually followed by probation), probation-only, and commitment to the state correctional institution. A good example of a community program – Wraparound Milwaukee – was implemented in 1995 and has shown great success in treating children with emotional disorders (see box below). The program provides support to both the juvenile and his or her family in working on issues and taking the necessary steps to make positive changes in the lives of both the juvenile and the family. Between 2003 and 2004, Wisconsin saw a reduction in its residential placement population of nine percent, partly due to Wraparound Milwaukee.[41]

Wraparound Milwaukee Program Overview[42]

Unique Managed Care Entity – Wraparound Milwaukee is a unique type of managed care entity. It began in 1995 with a six year, $15 million grant from the Center for Mental Health Services. Its primary focus is to serve children and adolescents who have serious emotional disorders and who are identified by the Child Welfare or Juvenile Justice System as being at immediate risk of residential or correctional placement or psychiatric hospitalization. Wraparound Milwaukee serves an average enrollment of 570 youth and their families.

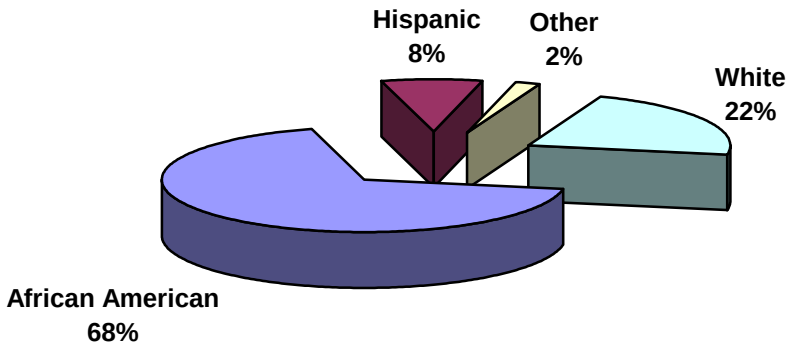
Funding – **A** combination of several state and local agencies, including the Bureau of Milwaukee Child Welfare, the County's Delinquency and Court Services: Behavioral Health Division, and the State Division of Heath Care Financing (which operates

Medicaid) provides funding for the system. Funds from four agencies are pooled to create maximum flexibility and a sufficient funding source to meet the comprehensive needs of the families served. As a part of the County's Behavioral Health Division, Wraparound Milwaukee oversees the management and disbursements of those funds by acting as a public care management entity.

Care Coordination Services – Wraparound Milwaukee contracts with nine community agencies for the approximately 72 care coordinators who facilitate the delivery of services and other supports to families using a strength-based, highly individualized wrap-around approach. Wraparound Milwaukee has also organized an extensive provider network of 204 agencies and individual providers that can offer an array of over 80 services to families. A Wraparound Milwaukee-operated Mobile Urgent Treatment Team ensures families have access to crisis intervention services when needed.

Role of the Family -- Wraparound Milwaukee involves families at all levels of the system and aggressively monitors quality and outcomes. It operates from a value base that emphasizes building on strengths to meet needs- one family-one plan of care. Assistance could include the following services as appropriate: cost-effective community-based alternatives to residential treatment placements, juvenile correctional placement, and psychiatric hospitalization. Wraparound Milwaukee also focuses on increased parent choice and family independence; and care for children in the context of their family and community.

Figure 3 Ethnic representation of 2004 enrollees in Wraparound Milwaukee



Source: Wraparound Milwaukee Annual Report, 2004

Though Wisconsin is taking the steps forward in order to more effectively work with the juvenile population, the disparity in gender and race is stark. Wraparound Milwaukee served 960 youth in 2004, of which 77 percent were male, 68 percent were African American, and 8 percent Hispanic. Although minority youth account for only one-third of the United States juvenile population,[43] and only 19 percent of the juvenile population in the state of Wisconsin, the minority youth accounted for 78 percent of the youth receiving services.

Texas[44]

In 1998, Texas began a push to promote Medicaid enrollment among children in the juvenile justice system. There was little consideration for the enrollment of this population earlier because of the bar on the use of Medicaid funds for those in public institutions. However, since only three percent of Texas youth are committed to public institutions (leaving the other 97 percent eligible for Medicaid-funded treatment), the state reconsidered. Since 1998, local probation offices have worked (at intake interviews performed when a juvenile becomes involved in the system) to screen every juvenile for Medicaid eligibility using an automated application system. If the child appears to be eligible, the juvenile probation officer can complete the form in the office, get signatures from the responsible adult present, and submit the form for review. This small step, which takes about 10 minutes on average, has increased the number of Medicaid enrollees in the system..

Like Alaska, Texas does not utilize Targeted Case Management (TCM). While the funds that can be pulled down in association with TCM could help fund services provided to the juveniles in the justice system, the administrative costs associated with maintaining appropriate documentation are high, and there is a risk that overlapping funding streams could lead to problems with double billing. Texas' decision not to request reimbursement on those funds does not impact the treatment provided to the juveniles, which is funded from other sources.

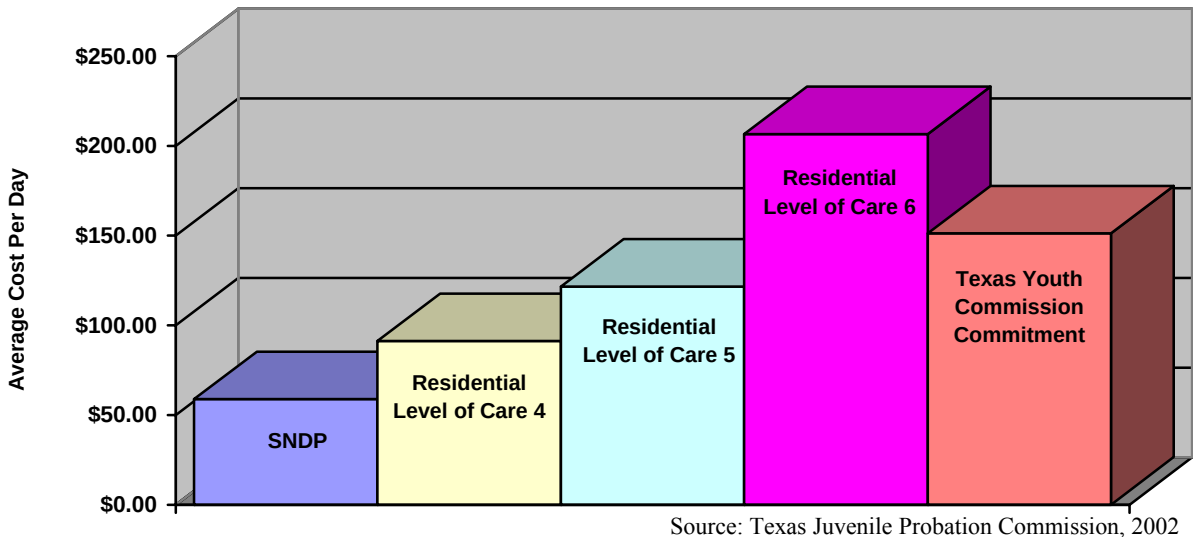
A Special Needs Diversionary Program (SNDP) began in 2001 as an attempt by the Texas Legislature to keep juveniles involved in the justice system who have identified mental health needs in the least restrictive placement possible and prevent further involvement with the justice system. The program involves a specialized juvenile probation officer and a mental health practitioner who provide case management, referral, and services for a period of four to six months.

Basics of the Special Needs Diversionary Program

- Initial case plan completed within 72 hours of enrollment.
- Plan includes, at a minimum, juvenile, parent, and staff input.
- Formal case plan review conducted monthly.
- Juvenile and family receive three to five contacts weekly by program staff (two of which occur in the home).
- Services provided include individual and family counseling, skills training, chemical dependency education, etc.
- Transition period (to assist juvenile and family in relying more on community support and less on formal program support) built-in to program no later than two months prior to projected discharge.
- Average length of stay in program: 4 ½ months.

Aside from keeping the juveniles in the community and demonstrating a 72 percent rate of successful completion, the program also provides a less costly alternative to residential treatment. The state identified the four residential placement options typically utilized for the target population of juveniles served by the SNDP program. The SNDP cost of $58.93 per day is considerably lower than the costs of the alternative residential placements (See Figure 4). By diverting more than half of the juveniles eligible for the program, the savings to the state have been significant, and the youth involved received quality treatment. The overall findings of the evaluation of the SNDP showed that mental health problems *are* prevalent among the juvenile justice population; therefore having the mental health and juvenile justice agencies join forces fills the gap in services for this population.[45]

Figure 4 Comparison of average per day cost of SNDP, residential level of care rates and Texas Youth Commission commitment



Source: Texas Juvenile Probation Commission, 2002

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FINDINGS

Given the lessons learned in state programs and current research on serving the juvenile justice population, there are a number of options available to states to increase access to health care services.

1. Screen young people for Medicaid eligibility at intake. The process should be required and standardized in order to ensure that all juveniles are screened appropriately so that none are able to "slip through the cracks."

2. Make the connection to Medicaid prior to re-entry into the community. Training juvenile justice staff on Medicaid eligibility helps to speed up the process of determination and enrollment. Designating specific workers to process juvenile justice applications (because of the quick turn-around needed and special circumstances presented) also appears to help with making the connection. At the very least, assisting families with applications for Medicaid is necessary.

3. Consider implementing presumptive eligibility for this population. The use of presumptive eligibility for enrollment in Medicaid would provide coverage during the 45 to 90 days it takes for application processing upon re-entry into the community. Presumptive eligibility would promote access to the services juveniles need in order to have uninterrupted medical services. The juvenile justice system could refer those children that appear Medicaid-eligible to qualified providers in the community where their eligibility could be assessed and presumptive eligibility granted if appropriate.

4. Ensure use of Early and Periodic Screening, Diagnosis, and Treatment services when appropriate (for Medicaid-eligible children)**.** The use of EPSDT for those cases in which a child does not qualify for continued services relating to a medically diagnosed condition could help overcome the barriers associated with limits in a state Medicaid plan. For example, if a state plan limits the number of counseling sessions a child can receive, but more are medically necessary, EPSDT services could fill in the gap and allow for more services.

5. Ensure that agencies work together and focus on providing care and treatment to the juvenile. Spending time attempting to figure out which agency should have primary responsibility for each child wastes resources and time. Cooperation among agencies is integral to successful treatment for juveniles such as in the Alaska model.

6. Expand sentencing options from basic incarceration to treatment-centered services. Costs associated with providing services such as day treatment are lower and have shown a higher rate of success than incarceration (as noted in Texas' SNDP). In addition, Medicaid funding can be accessed when a juvenile is not placed in a public institution, which helps increase the pool of funds available to provide services to Medicaid-enrolled juveniles.

7. Involve parents and families in services being rendered. As the New York program demonstrates, the involvement of parents in treatment can be beneficial. Some states even provide mental health counseling to parents if needed. Although parent services are not Medicaid-reimbursable, they help improve the support, general health, and well-being of the child. When a child has a firm foundation, dealing with problems is much easier.

8. Provide mental health services, substance abuse services, and dental care during incarceration. States such as New York that have placed mental health clinicians in their public institutions have shown great progress. States such as Alaska that provide substance abuse treatment in conjunction with juvenile justice have reduced recidivism and improved public safety. Though some of these services cannot be Medicaid-funded, those who receive them have better integration into community mental health services than those who do not.

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CONCLUSION

The juvenile justice population consists of many different types of young people who require a range of services well beyond what juvenile justice programs were initially created to address. According to the Coalition for Juvenile Justice, "Emerging strategies and models to treat this population include collaboration across mental health, social services and juvenile justice systems (strategic planning, cross-training and providing services), diversion of youth from the juvenile justice system, [both physical and mental health] screening of all youth who come into contact with the juvenile justice system, use of community-based alternatives and appropriate treatment of juveniles placed in correctional facilities."[46] States are revamping their health and juvenile justice systems to more effectively meet the changing needs of this population.

Funding restrictions and administrative procedures have played a large role in the type and quality of services provided. Therefore, states have begun to examine how to best use Medicaid funding, and screen youth entering and leaving the juvenile justice system for Medicaid eligibility. Since a large number of services are not eligible for Medicaid funding, Medicaid cannot be used during incarceration, and some children do not meet Medicaid eligibility criteria, states use local and state-only funding when needed. According to the National GAINS Center, "in some systems the loss of medical assistance benefits does not prevent the person from accessing public treatment services, but instead shifts the full cost of mental health, substance abuse, and medical treatment to the local city, county, or state agencies that bear those costs without the federal assistance to which they are entitled."[47] In order to avoid unnecessary cost shifting, and to plan services for the wide range of problems this population presents, agencies need to work together so that the youth involved can move on to a more satisfying and productive life.

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Notes

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[28] The letter also included the following clarifications:
"An individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities."
The "other living arrangements" situation (described in Medicaid policy) does not apply to an individual who is involuntarily residing in a public institution.

FFP would not be available in the following situations:

1. Individuals who are being held involuntarily in detention centers awaiting trial
2. Inmates involuntarily residing at a wilderness camp under governmental control
3. Inmates involuntarily residing in halfway houses under governmental control
4. Inmates receiving care on the premises of the prison, jail, detention center or other penal setting.

[29] Letter from Jane Perkins, National Health Law Program (NC) to the National Association of Protection an Advocacy Systems. Dated: August 31, 2003. Referencing a letter from Mary Jean Duckett, Director, CMS Division of Benefits, Coverage and Payment, to Mr. Robert J. Raubach, Georgia Advocacy Office Dated: September 29, 1999.
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