Blueprint for Change: Funding Mental Health Services for Youth in Contact with the Juvenile Justice System

Prepared by

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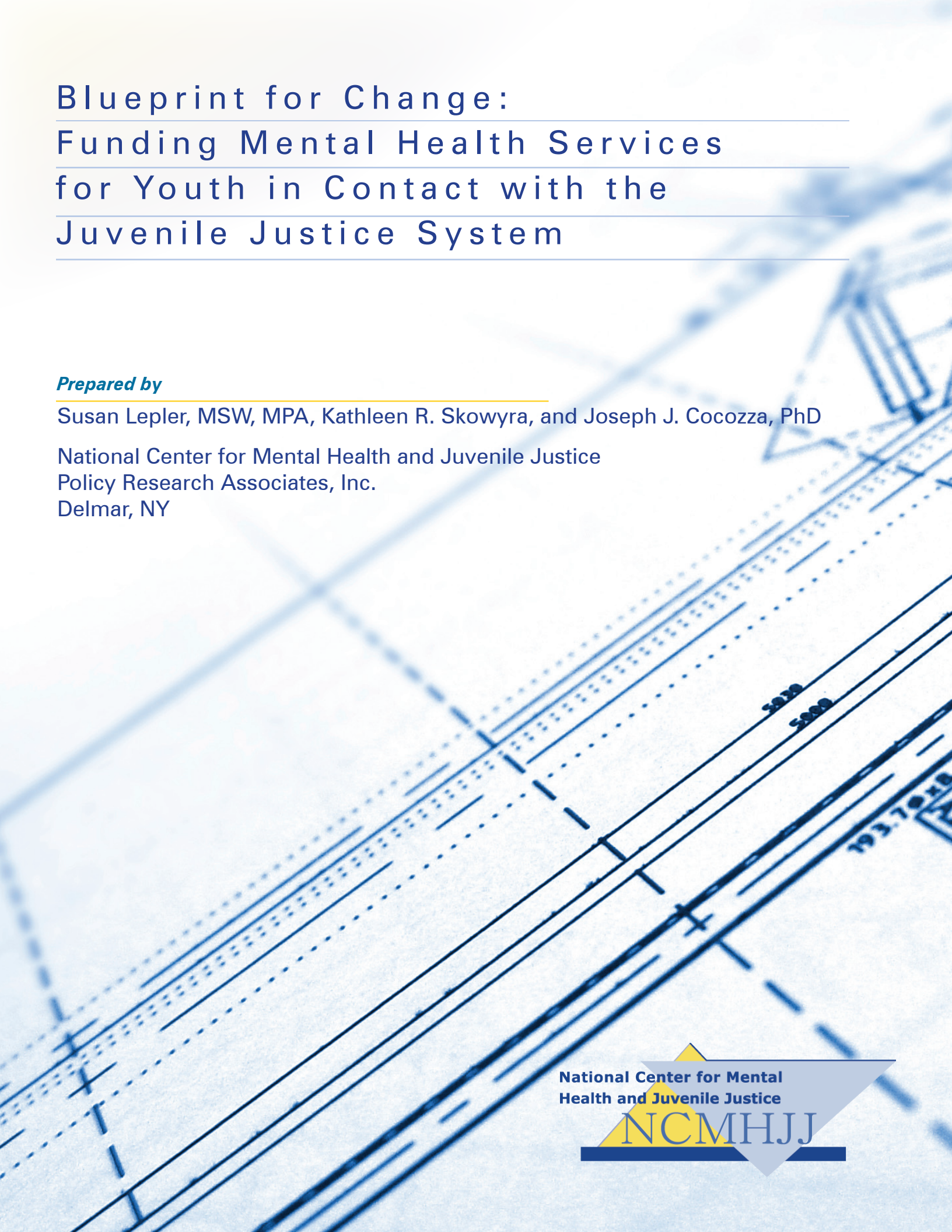

National Center for Mental Health and Juvenile Justice
NCMHJJ

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Introduction

There are large numbers of youth with mental health disorders involved with the juvenile justice system. Recent advances have resulted in the development of new tools, interventions, and technical assistance resources to help the field better identify and respond to this problem. Yet, a significant and remaining barrier to the full application of these new resources in the field is a lack of practical information about how to fund services and programs that provide mental health screening, assessment, and treatment services to youth involved with the juvenile justice system. In response, and building on its recently released report *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*, the National Center for Mental Health and Juvenile Justice (NCMHJJ) conducted a brief survey of promising programs highlighted in the *Blueprint*. The goal of this effort was to learn how these programs, which provide mental health services to youth involved with the juvenile justice system, are funded. As programs improve their response to these youth, it is critical that they have the knowledge and information necessary to fund and provide the best services they can. The results of this survey, along with the NCMHJJ's analysis of the findings, represent the first step in addressing this need.

Section One: Background

It is well established that the majority of youth in the juvenile justice system have mental health disorders. Findings from a number of recently conducted studies are strikingly consistent—approximately 70 percent of youth in the juvenile justice system meet criteria for a diagnosable mental disorder (Shufelt & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, Ko, & McReynolds, 2004). Further, recent estimates suggest that approximately 25 percent of youth experience disorders so severe that their ability to function is significantly impaired (Shufelt & Cocozza, 2006).

These new data, as well as efforts by national groups and organizations to promote awareness of the unmet mental health needs of many youth in the juvenile justice system, have led to the development of many new tools and resources, which are helping the field better identify and respond to these problems. These include:

- Mental health screening and assessment instruments for justice-involved youth, such as the MAYSI-2 and the V-DISC; (Grisso & Underwood, 2002; Grisso, Vincent & Seagrave, 2005);
- Evidence-based treatment interventions, such as Multi-Systemic Therapy and Functional Family Therapy, to treat disorders among juvenile justice youth (Elliot, Henggeler, Mihalic, Rone, Thomas, & Timmons-Mitchell, 1998); and
- Technical assistance resources that provide guidance to systems and communities interested in strengthening mental health treatment strategies for youth in the juvenile justice system (Skowyra & Cocozza, 2007).

Despite the availability of these tools and interventions, a major remaining barrier to their full implementation in many states and communities is a lack of information about how to fund mental health screening, assessment, and treatment services for youth involved with the juvenile justice system.

Blueprint for Change

In 2007, the National Center for Mental Health and Juvenile Justice (NCMHJJ) released *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*. This document, which was prepared with support from the Office of Juvenile Justice and Delinquency Prevention, offers a conceptual and practical framework for juvenile justice and mental health systems to use when developing strategies and policies aimed at improving mental health services for youth involved with the juvenile justice system. It captures the current activity of the field and presents it in a way that examines the juvenile justice system as a continuum, identifying the best ways to respond to youth with mental health needs at key points of contact, and providing recommendations, guidelines, and examples for how best to do this. In addition, the *Blueprint* includes detailed descriptions of over 50 promising programs that respond to youth with mental health needs in the juvenile justice system at critical points of contact within the processing continuum.

Since its release in 2007, the *Blueprint for Change* has aided numerous jurisdictions in their efforts to better address mental health issues within the juvenile justice system, and has emerged as an important resource for systems change. However, one issue that continues to be raised about the *Blueprint* and the promising programs it highlights is that of funding. Questions have repeatedly come up when the NCMHJJ has presented the *Blueprint* to the field: How do you fund mental health services for youth in the juvenile justice system? How are the programs described in the *Blueprint* funded? What resources exist to pay for mental health services for youth in the juvenile justice system?

Funding Mental Health Services for Justice-Involved Youth

To begin to answer these questions, the NCMHJJ undertook a review of the literature to identify publications that describe ways in which mental health services for youth in the juvenile justice system can and are being supported. The documents we identified during this review include:

- *Mix and Match: Using Federal Resources to Support Interagency Systems of Care for Children with Mental Health Care Needs* (Koyanagi, Boudreaux, & Lind, 2003);
- *Moving On: Federal Programs to Assist Transition-Age Youth with Serious Mental Health Conditions* (Koyanagi, Stine, Alfano, & Lind, 2005);
- *Financing Structures and Strategies to Support Effective Systems of Care—A Self-Assessment and Planning Guide: Developing a Comprehensive Financing Plan* (Armstrong, Pires, McCarthy, Stroul, Wood, & Pizzigati, 2006); and
- *Public Financing of Home and Community-Based Services for Children and Youth with Serious Emotional Disturbances: Selected State Strategies* (Ireys, Pires, & Lee, 2006).

These, as well as other documents identified during this search, tended to focus on one of two areas:

1. **Detailed reviews of Federal funding streams that could be used to pay for services for youth with mental health needs.** These reviews included comprehensive examinations of Federal funding streams, including Federal entitlement programs as well as discretionary grants, which could be used to support mental health services for youth. The most frequently cited Federal entitlement programs for youth with mental health needs include:
   - Medicaid
   - Individuals with Disabilities Act (IDEA) funds
   - Title IV-E and IV-B funds
   - State Child Health Insurance Program (SCHIP)
   - Block Grant funds from the Office of Juvenile Justice and Delinquency Prevention (OJJDP)
   - Maternal and Child Health Block Grant
   - Social Services Block Grant (Title XX)
   - Temporary Assistance for Needy Families (TANF)

   Frequently cited Federal discretionary grants include:
   - Discretionary grants from the Department of Health and Human Services, including the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children and Families (ACF)
   - Discretionary grants from OJJDP
   - Discretionary grants from the Department of Education
2. **Guides for developing financing strategies for services for youth with serious emotional**

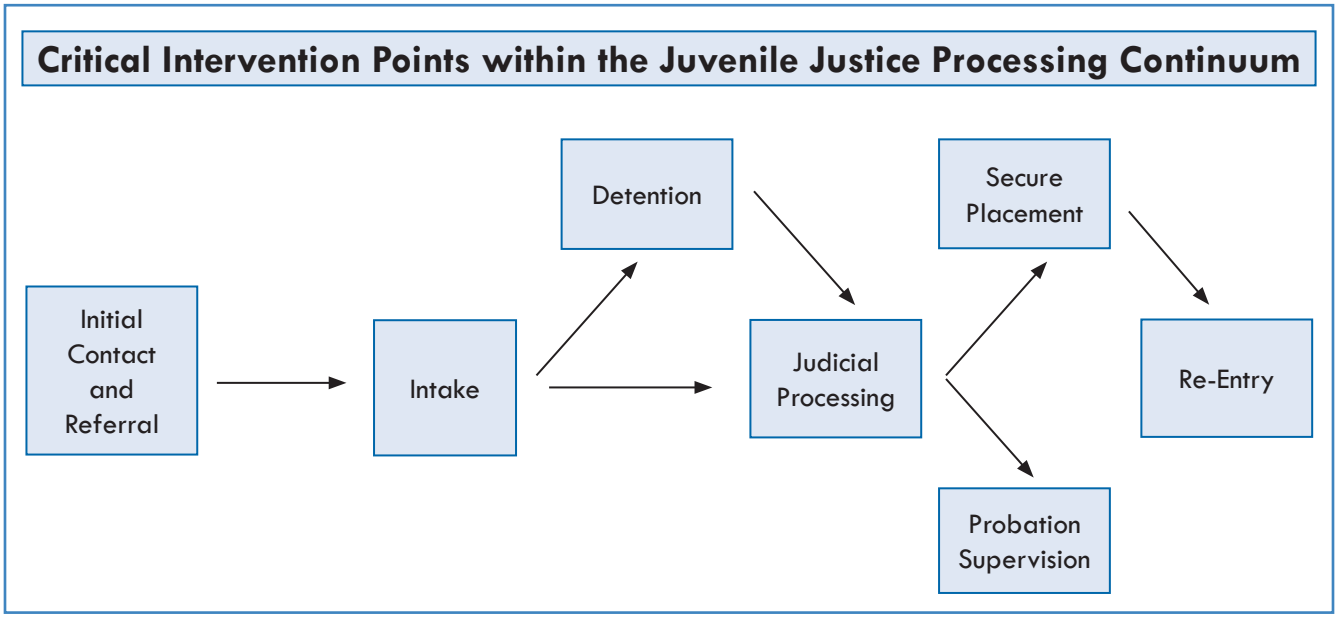


Figure I. Critical Intervention Points

disturbances. These reviews tended to identify financing approaches and structures that could be used to support systems of care for children and youth with serious emotional disturbances and their families.

While these documents produce a wealth of useful information, our examination illuminated two important and remaining gaps in the knowledge base:

1. A lack of information about using the available Federal funding sources to pay for mental health services and programs specifically for youth involved with the juvenile justice system, and
2. A lack of practical information about how jurisdictions are actually using the Federal funding, as well as other sources of funds, to pay for programs and services for juvenile justice–involved youth at the state and local level.

Given this, the NCMHJJ initiated a survey-based project to learn more about how programs that serve youth with mental health needs involved with the juvenile justice system are using public (Federal, state, and local) and private funding to support their programs. As states and communities strive to improve their response to these youth, it is critical that they have information and knowledge about how to fund necessary services and supports. The goal of this effort was to produce a report that provides practical examples of how select promising programs that serve youth involved with the juvenile justice system are funded.

Methodology

The NCMHJJ selected seven programs featured in the *Blueprint for Change* to participate in a survey. The programs selected correspond to critical intervention points identified in the *Blueprint for Change*. These critical intervention points represent decision-making points within the juvenile justice continuum that offer opportunities for improved collaboration, identification, diversion, and treatment for youth with mental health needs. The critical intervention points are

- Initial contact and referral
- Intake
- Detention
- Judicial Processing
- Probation supervision
- Secure placement
- Re-entry

(See Figure 1.)

The programs selected for the survey are shown in Table 1 together with the critical intervention point associated with each. Each program director was contacted to determine their interest in participating in the survey. Once the program director agreed, the NCMHJJ emailed a brief survey that included four parts:

I. **Background Information.** Part I asked for program/fiscal contact information, program start date, number of youth served in 2005 and information on Medicaid eligibility.

Critical Intervention Point	Promising Program
Intake (Juvenile court or Probation)	Texas Special Needs Diversionary Program
Secure Pre-Trial Detention	Bernalillo County, New Mexico Juvenile Detention Center
Judicial Processing	Cook County, Illinois Juvenile Court Clinic
Dispositional Alternatives	Washington State's Integrated Treatment Model (ITM) Connecticut's Multi-Systemic Therapy Initiative for Children Summit County Ohio's Crossroads Program
Re-Entry	Washington State's Family Integrated Transitions Program

Table 1. Promising Programs Selected for Funding Survey

II. **Funding Questions.** Part II included a series of open-ended questions about the overall funding arrangement for the program, including the funding history, the level of collaboration with other systems, the existence of interagency agreements, the biggest funding challenges, and the most important lessons learned.

III. **Total Program Funding by Source.** Part III included a chart asking for aggregate 2005 budget information for each source of funding for the program.

IV. **Funding Detail.** Part IV included a chart with three subsections seeking information on the specific types of operating aid or program specific grants supporting the program. Of particular interest was learning the original source of any aid/grants used to support the program.

All programs were given approximately one month to complete the survey. Once the survey results were submitted to the NCMHJJ and reviewed, follow-up communication was initiated with each of the program directors to seek clarification and additional information as necessary. Once the follow-up was completed, the survey results were summarized to include:

- Detailed program and funding descriptions, including the overall funding history, current funding arrangement, level of interagency funding collaboration, and biggest funding challenges;
- A cross-program review of key findings that identifies similarities, variations, and overall trends with respect to program funding sources;
- Key funding lessons learned from the experiences of the surveyed programs; and
- A discussion of proposed funding directions for the field.

The survey asked programs to identify, to the best of their ability, the amount and source of funding received in the most recent fiscal year—typically 2005. Readers should review the findings with two points in mind. First, because of the complexities of public sector funding, programs that receive funding from local government may not know whether some or all of these funds originate at the state or Federal level. Second, for programs that deliver all aspects of the service model themselves, the information aptly describes the total funding for the program. For programs that collaborate with other providers who deliver various interventions for the youth but are funded through separate mechanisms, the program's funding information tells a partial story of the total resources devoted to serve the youth. The findings are presented in the following sections.

Section Two: Program Funding Descriptions

The NCMHJJ surveyed seven programs that were featured in the *Blueprint for Change* to better understand how these programs were funded. The surveyed programs are:

1. The Texas Special Needs Diversionary Program
2. The Bernalillo County, New Mexico Juvenile Detention Center
3. Cook County, Illinois Juvenile Court Clinic
4. Washington State's Integrated Treatment Model
5. Connecticut's Multi-Systemic Therapy Initiative for Children
6. Summit County Ohio's Crossroads Clinic
7. Washington State's Family Integrated Transitions Program

Detailed program and funding descriptions for each of the seven programs are presented in this section.

Special Needs Diversionary Program, Texas

Program Information

The Special Needs Diversionary Program (SNDP) is a jointly funded statewide initiative, involving both the juvenile justice and mental health agencies, designed to provide youth with mental health services. SNDP serves as both a diversion program for justice-involved youth and a reintegration program for youth released from secure facilities. To be eligible for the program, youth must be between 10 and 18 years of age with a primary mental health diagnosis (DSM-IV, Axis I-MH) and have a GAF score of 50 or below, be classified as seriously emotionally disturbed in special education, or be at risk for removal from the home due to psychiatric reasons. There are multiple points of entry to the diversion program, and referrals can be made from virtually all key juvenile justice processing points (from intake through post-adjudication).

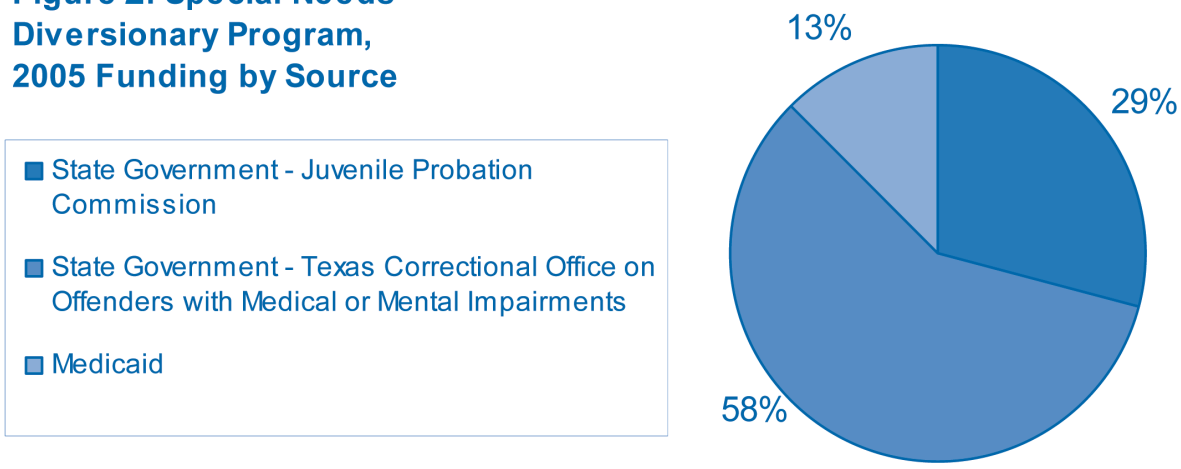
Co-located Probation/Licensed Practitioners of the Healing Arts (LPHA) teams provide case management, services, and supervision to youth in the program. Each team has a caseload of 12 to 15 youth who are on probation. These teams are responsible for jointly securing, providing, or supervising the provision of services to youth on their caseload. The state of Texas requires Probation to use the MAYSI-2 (a mental health and substance use screening tool for use in juvenile justice settings) to screen all youth at Probation Intake. The results of the screen are passed to the Probation/LPHA teams, where youth then undergo a clinical assessment and family interview. Following these assessments, an individualized treatment plan is developed for the youth and family. Currently, there are 16 programs involving 19 local juvenile probation departments and 38 specialized teams in operation throughout the state.

All program services are based on a wraparound philosophy of team treatment planning. The Probation/LPHA teams strive to provide the majority of services in the home or school. Services include benefit coordination to assist with Medicaid or CHIP enrollment; psychiatric services, including medication management and group and individual counseling; health care; parent and child support groups; job training services; and transition planning to prepare for discharge from the program. Mental health services not directly provided by the teams are available through the local mental health authority. Program compliance and progress is monitored through unscheduled home visits by the youth's probation officer three times per week and a scheduled visit by the LPHA therapist once per week. Participating families also have three to five program contacts per week, at least two of which are in the home. In 2005, the program served 1,514 youth.

Funding Information

SNDP is jointly funded by the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) and the Texas Juvenile Probation Commission (TJPC). The Texas Legislature originally allocated $2 million dollars in general revenue to the TJPC to contract with local juvenile probation departments to fund specialized juvenile probation officers. They also allocated $5 million dollars to TCOOMMI to contract with local mental health

Figure 2. Special Needs Diversionary Program, 2005 Funding by Source



Source: Program Data

authorities and the Texas Department of Health Services to partner a mental health professional (or a team of professionals) with the specialized juvenile probation officers to provide intensive in-home services to youth participants. Because the TCOOMMI funds have been reduced since the original allocation in 2001, county governments have had to pick up the cost of salary and cost of living adjustments for the specialized juvenile probation officers, as well as portions of mental health treatment costs not covered by the initial funding stream. However, the county contributions are not required, the amounts vary by county, and are not tracked by the state. See Figure 2 for a breakdown of 2005 program funding.

Collaboration

The unique funding arrangement of this program requires collaboration at the state and local levels. Interagency agreements are in place between the TJPC and TCOOMMI, and between the local probation departments and the local mental health authorities. In addition, some of the programs have extended their local collaborations to include other providers to enhance the service delivery capacity of their programs.

2005 Program Funding

$1,974,033	**State Government: Juvenile Probation Commission**
$3,935,204	**State Government: Texas Correctional Office on Offenders with Medical or Mental Impairments**
$ 850,729	**Medicaid**
$ 6,759,966	**Total Program Funds**

Bernalillo County Juvenile Detention Center, Albuquerque, New Mexico

Program Information

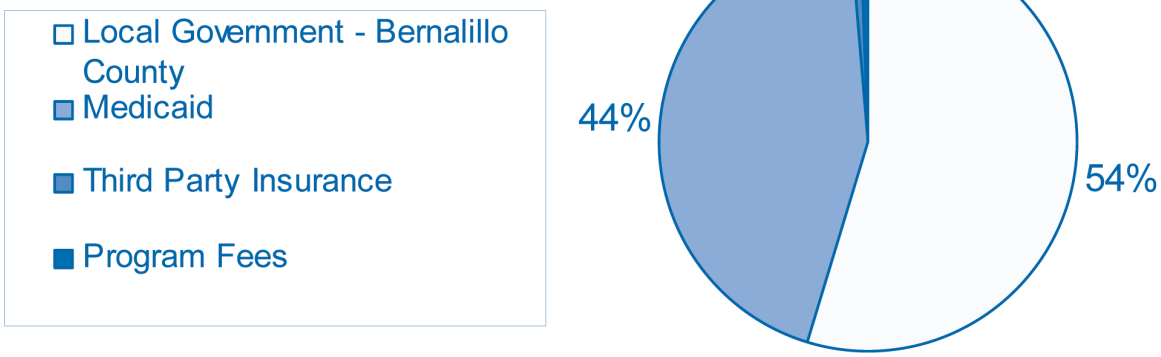
The director of the Bernalillo County Juvenile Detention Center (BCJDC) created an innovative response to the increasing number of youth with mental health disorders entering the juvenile detention center. The BCJDC developed an intake process that uniformly identifies youth with mental health needs and diverts these youth to a community mental health clinic, the Children's Community Mental Health Clinic (CCMHC), which is located near the detention facility.

The initiative began in 1999 when the BCJDC director launched a system reform effort designed to reduce the detention center population, increase diversion to community programs, and provide mental health services to youth in the community or stabilize them until placement in an appropriate facility or program was possible. With the support of local elected officials, judges, the probation department, and community providers, a two-pronged approach was developed to first identify, through intake screening, youth with mental health needs, and second, provide them with an array of services.

Youth brought to the detention center undergo a comprehensive intake screening process. The first part involves a brief screen to determine the youth's immediate placement—either in juvenile detention; in the community custody program, which is a probation-monitored diversion program; or release home. The second part of the process involves a medical intake screen, administered by a nurse who is at the detention center 24 hours a day, seven days a week. Both of these intake screens are conducted immediately when a youth arrives at the detention facility, and the accompanying police officers are required to wait until the detention center staff has determined the youth's placement. The nursing staff at the detention center and the mental health clinic rotate between the two buildings, allowing for consistent, high quality screening and knowledgeable referrals as well as familiarity with the youth. Youth identified through the screening as needing immediate mental health services are walked from the detention center to the mental health clinic located about 200 yards away. Other youth are given an appointment for a follow-up assessment, usually the next day.

The Clinic serves all youth in Bernalillo County who would benefit from the services provided by a mental health treatment team. Referrals to the Clinic can be made by the juvenile detention center, care providers, parents, or self-referral, thereby reducing any incentive to refer youth to the detention center simply to access mental health services. Staff at the Clinic include part-time child psychiatrists, case managers, clinical coordinators, and administrative staff. In addition, community mental health professionals, who are not employees of the county or the Clinic, provide clinical services to youth at the Clinic. Services provided include evaluation and assessment, individual and group therapy, medication management, substance abuse treatment, case management, and crisis

Figure 3. Bernalillo County 2005 Funding by Source



Source: Program Data

management. Services are provided to youth in detention as well as youth in the community. Further, the CCMHC receives a daily list of youth released from detention. Clinic staff provide outreach services and continue to provide services to all youth released from detention, even if a youth is placed by a judge in a residential setting. Clinic nurses provide training to BCJDC staff on the basic signs and symptoms of mental illness and the possible side effects of certain medications.

Since the initiative has been in place, the BCJDC has seen a reduction in its population and reduced lengths of stay. Money saved by reducing the population at the detention center, combined with Medicaid reimbursement, keeps the clinic operating without any additional funding. Staff no longer needed at the detention center were trained and reassigned as case mangers for the clinic.

In 2005, approximately 474 youth were served at the Clinic. Over 90 percent of these youth were Medicaid eligible.

Funding Information

Initially, Bernalillo County provided funding for the Clinic and reassigned staff positions from the detention center for the start-up of the program. In addition, three of New Mexico's Managed Care Organizations provided a $74,000 grant for start-up costs. One of these organizations also provided a part-time staff person to assist Bernalillo County with the billing and payment processes for the Clinic. Finally, Bernalillo County received a donation of two buildings that were moved to the detention center grounds to house the new Clinic.

In 2005, the Clinic was supported by a combination of sources including county funds, Medicaid, private insurance and program fees. The majority of youth served by the Clinic are Medicaid eligible. In 2006, the Clinic received two grants—one from the New Mexico Children, Youth and Families Department's Juvenile Justice Advisory Board, and one from Value Options, a managed care organization in New Mexico. These grants are used to support training and program development, and the expansion of the Clinic model into a rural part of the state. See Figure 3 for a breakdown of 2005 funds that support the Clinic.

Collaboration

The Clinic has agreements with community mental health providers, including a clinical psychologist and clinical therapists, to provide treatment services to clients at the clinic. They are not Clinic or county employees, but provide services at the Clinic and are responsible for their own reimbursement. In addition to the community providers, the Clinic provides clinical staff, including part-time psychiatrists (under contract with the University of New Mexico), case managers, and clinical coordinators, as well as administrative staff who handle billing for the clinic and community clinicians.

2005 Program Funding

$94,028	**Local Government: Bernalillo County**
$75,576	**Medicaid**
$ 1,230	**Third Party Insurance**
$ 944	**Program Fees**
$171,778	**Total Program Funds**

Cook County Juvenile Court Clinic, Illinois

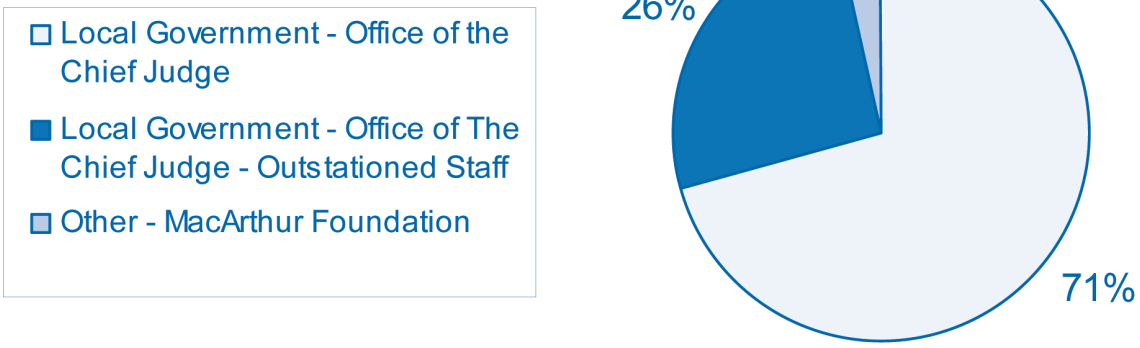
Program Information

The Cook County Juvenile Court Clinic began as a collaborative project between the John D. and Catherine T. MacArthur Foundation, the Children and Family Justice Center at Northwestern University School of Law, and the Office of the Chief Judge of the Circuit Court of Cook County. The project's goal was to evaluate and improve the acquisition and use of clinical information in Cook County's Juvenile Court. The research led to the conclusion that an effective clinic must provide an array of services, including but not limited to, forensic evaluations. In June 2003, the model was implemented as the Cook County Juvenile Court Clinic under the authority of the Circuit Court of Cook County and funded by Cook County.

The Clinic serves both the juvenile justice and child protective divisions of the Cook County Juvenile Court. Clinic services include providing consultation to judges and court personnel regarding requests for mental health information, responding to court-ordered requests for forensic evaluations, gathering and providing information on mental health interventions, training and education on issues related to mental health information and court proceedings, and program evaluation that monitor's the clinic's operation and provides data for research and development. In addition, the Clinic serves as a national multidisciplinary training site for students in the fields of law, social work, and psychology.

To carry out its multiple functions, the Clinic's staff includes master's level social workers, doctoral level forensic psychologists, and lawyers. The Clinic's staff work as a team to address requests for clinical information that arise in the context of court proceedings. Each courtroom is assigned a "clinical coordinator." Clinical coordinators have a background in mental health and are trained on court proceedings. Clinical coordinators provide guidance to lawyers, judges, and probation officers regarding requests for clinical information, screen out inappropriate requests, and distinguish between requests that require a forensic evaluation and requests for information that primarily concerns services. When a forensic evaluation is needed, clinical coordinators document the specific request, follow up on the progress of pending requests, and serve as the conduit between the court and clinician on issues relating to a request for clinical information. Requests for forensic evaluations are referred to the Clinic by court order. Forensic evaluations are conducted by a clinician, usually a psychologist, and the clinical coordinator delivers the evaluation to the parties on a specified date, generally two days in advance of the next court date. The Clinic's forensic evaluations include multiple interviews with the evaluation subject(s) and family members, collateral interviews, and review of relevant records. Some of the Clinic's forensic evaluations include information on available community-based mental health and substance abuse intervention resources. This information is gathered, updated, and provided by the Clinic's resource consultation staff. Resource information also is provided in response to

Figure 4. Cook County 2005-06 Funding by Source



Source: Program Data

requests for clinical information primarily concerning services ("service requests"). Through its services, the Clinic helps judges, lawyers, and probation officers make decisions that promote better outcomes for the children, youth, and families involved in court proceedings.

Funding Information

Currently, the Cook County Office of the Chief Judge provides most of the funding for the operation of the Juvenile Court Clinic. The Office of the Chief Judge also contributes staff to the Clinic, including six full-time psychologists, two social workers, and a receptionist. In addition to the support from the county, the Clinic receives funding from the John D. and Catherine T. MacArthur Foundation to support specific portions of the Clinic's work. Since the opening of the Clinic in 2003, the MacArthur Foundation has provided funding for the development and implementation of a community-based mental health resource database, the development and implementation of the Clinic's program evaluation work, a forensic post-doctoral fellowship position, and some of the Clinic's dissemination and technical assistance projects. See Figure 4 for a breakdown of 2005–06 program funds.

Collaboration

The fiscal agent for the Clinic is Northwestern University's Law School. The Law School contracts with the county to operate the Clinic, resulting in a unique public/private partnership. In addition, the Office of the Chief Judge contributes nine staff to the Clinic, whose positions are administratively housed within the county Probation Department. While no formal interagency agreements exist to support this funding and staffing arrangement, the Clinic is collaboratively supported by a number of public and private entities.

2005–06 Program Funding

$1,438,789	**Local Government: Office of the Chief Judge**
$ 535,000	**Local Government: Office of the Chief Judge – Out-stationed Staff***
$ 67,997	**Other: MacArthur Foundation**
$2,041,786	**Total Program Funds**

*** Estimated annual value**

Washington State Integrated Treatment Model in Juvenile Rehabilitation Administration Facilities

Program Information

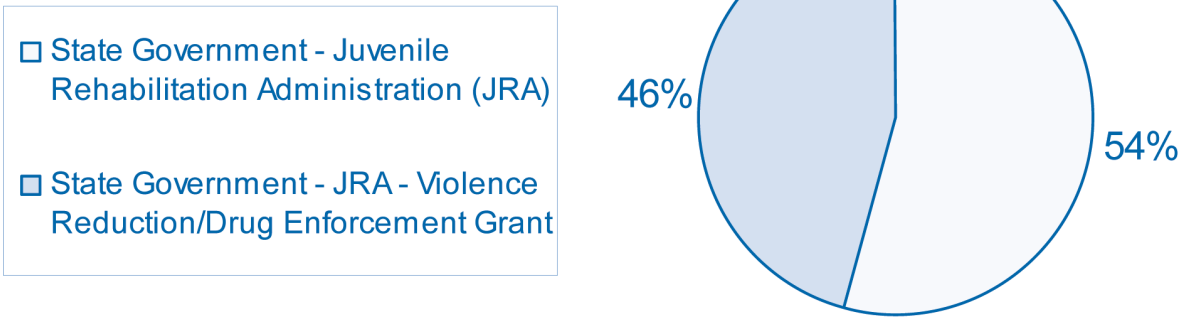
The Integrated Treatment Model (ITM) is the umbrella term for the combination of approaches utilized by Washington State's Juvenile Rehabilitation Administration (JRA) within their residential programs and parole aftercare services. The design of the program incorporates best practice interventions for juvenile justice–involved youth, such as Cognitive Behavioral Therapy (CBT) and Functional Family Therapy, into a core two-part approach that addresses the needs of youth and their families from the point of admission through the completion of parole aftercare. Both treatment approaches have been demonstrated to be effective with mentally ill and substance abusing/dependent youth.

JRA's residential programming includes four institutions (two with a mental health focus), a basic training camp, and six state community facilities, and two contracted community facilities. Youth also participate in parole aftercare services following release to the community. ITM is the overarching service model structuring services to all youth in these settings—it incorporates CBT in residential settings, and Functional Family Parole (FFP), a family-focused parole case management model based on Functional Family Therapy (FFT), in parole aftercare settings.

Youth are screened by staff upon intake to the institution or facility and referred for mental health services if needed. Treatment for youth in residential settings includes engaging and motivating clients, strength identification and skill building as part of CBT. The treatment is modeled after Dialectical Behavioral Therapy (DBT), developed by Marsha Linehan, Ph.D., primarily for difficult-to-treat youth with complex issues and severe behavior problems. DBT focuses on enhancing a youth's behavioral skills to deal with difficult situations; motivating the youth to change dysfunctional behaviors; and ensuring that the new skills are used in daily institutional life and generalize back to the community.

Families are invited to learn about their child's care and treatment, but due to travel and other constraints they may have limited involvement while youth are residing in institutions. However, as the youth moves back to the community, the family becomes the central focus. As part of ITM, youth transition into a Functional Family Parole (FFP) program immediately after release from the institution. FFP has been in place since 2002. Modeled after Functional Family Therapy (FFT) created by James Alexander, Ph.D. and Thomas Sexton, Ph.D., Functional Family Parole addresses the need for families to examine and improve their natural ability to solve problems and access resources in their communities. Counselors also help the youth apply the newly acquired skills and strengths developed in the residential placement. While ITM incorporates two systems of treatment, JRA works to blend them when possible, with families participating in skills groups and family sessions when visiting the

Figure 5. Washington State ITM 2005 Funding by Source



Source: Program Data

institutions, and some parole settings offering DBT skills groups and skills coaching in the community.

Ongoing goals of the ITM include an attempt to link the interventions by providing cross-training to staff; working together with youth and families at all stages of the process; and developing treatment adherence measures and quality improvement processes. Specialized residential treatment based on DBT is being developed for youth with sex offending and substance abuse behavior. One key finding of the ITM is the need for ongoing in-house training to ensure continuous treatment delivery during times of staff turnover. Resources have been allocated to focus on this priority. A core of program administrators has been trained by consultants who have in turn, become trainers for incoming staff. Outside consultants are brought in as necessary.

Future evaluations will focus on identifying where in the process positive effects occur and on the long-term results of the treatment model. No outcome studies are currently underway; however, it is anticipated that outcomes will indicate reductions in assaultive behavior, self-injurious behavior, the use of isolation within the institutions, and increased use of resources and services in the community.

ITM is a system approach that is being implemented with all youth who are in JRA custody. In 2005, 2,579 youth, including all youth in institutional settings, community-based facilities and on parole, received services as part of the ITM Model. Every residential unit, including the community-based facilities, uses DBT with every client. Every parole officer is using FFP with every family. All JRA line staff are using the tools and strategies of ITM when they interact with youth and families, and all managers are using ITM tools to help line staff meet standards of care. Additional funds are being requested from the legislature to permit further development and implementation of improved quality assurance standards specific to the treatment model.

Funding Information

There is no special funding specifically for the ITM Model. It is the overarching treatment model within JRA and, as such, is funded entirely within JRA's operating budget. JRA's overall operating budget for FY05 was $101,351,605. The ITM program is funded through a small carve-out from within this operating budget. In 2005, the total amount of funding spent on the program was $400,053. This included approximately $216,720 in general operating funds and $183,333 in funds from a JRA Violence Reduction/Drug Enforcement Grant. See Figure 5 for a breakdown of 2005 program funds.

Collaboration

Despite there having been discussions at the state level concerning braided or blended funding for the ITM program, there are currently no interagency agreements at the state or local level that support the funding for the program. All funding for the program is provided by JRA. JRA subcontracts with service providers in the community to offer specific treatment services to clients while on parole. JRA also contracts with FFT, Inc. for training and consultation on FFP. In addition, JRA contracts with Indiana University to provide information on FFP research.

2005 Program Funding

$216,720	**State Government: Juvenile Rehabilitation Administration**
$183,333	**State Government: Juvenile Rehabilitation Administration – Violence Reduction/Drug Enforcement Act**
$400,053	**Total Program Funds**

Connecticut's Multi-Systemic Therapy Initiative for Court-Involved Children

Program Information

In 2000, the Connecticut State Legislature mandated that the Connecticut Policy and Economic Council (CPEC), a nonpartisan public policy organization, evaluate the costs and benefits of programs serving juvenile offenders and how they impact recidivism. Juvenile justice services in Connecticut are administered by two agencies: the Connecticut Judicial Branch, Court Support Services Division (CSSD), which provides pretrial and post-disposition probation services for status offenders and delinquents, and the Department of Children and Families, which provides services for committed delinquents at the state's training school and residential treatment facilities, and through aftercare services. The study was completed in late 2002 and the results indicated that while youth did well in the CSSD-administered programs, there was little evidence of long-term gains in functioning or decreases in recidivism. CPEC found that youth who attended some programs actually experienced higher recidivism rates than youth who did not participate. This study served as the impetus for CSSD to consider funding different program models for the youth they serve.

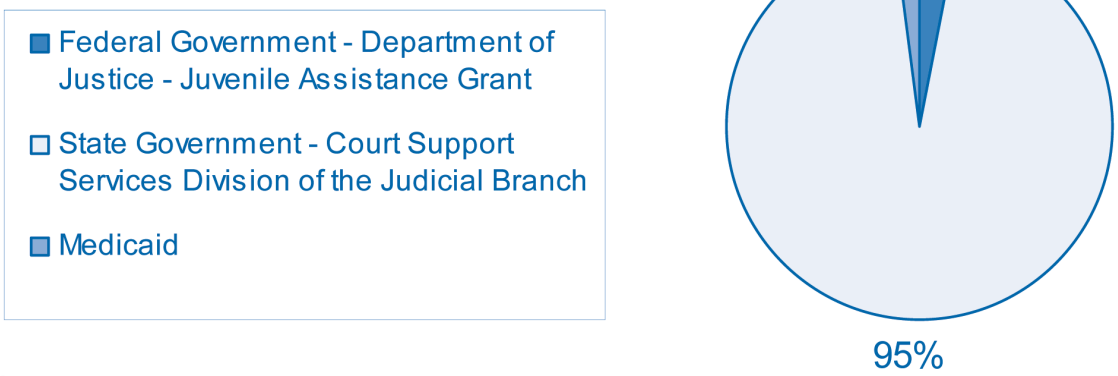
After an extensive literature review to identify the most promising practices for serving youth in the juvenile justice system, the CSSD leadership committed to making Multi-Systemic Therapy (MST) available on a statewide basis. From 2003 to 2005, the state of Connecticut created 15 MST teams, increasing the number of MST slots available to almost 400, and expanding MST into all juvenile courts as a dispositional alternative to incarceration. Youth are referred to these programs based on risk and need and the completion of a pre-dispositional study. MST serves as an alternative to commitment to the state training school or a residential treatment facility. In 2005, the MST program served approximately 420 youth and families.

Funding Information

CSSD-contracted MST services are overwhelmingly funded with state dollars. CSSD initially funded MST services by terminating approximately $6.5 million in existing alternative sanctions contracts for Juvenile Supervision and Reporting Centers (JSRCs), Intensive Outreach and Monitoring (IOM), and Gateway programs. The rationale for this decision was to terminate contracts with providers who were providing services that were not evidence-based and that did not demonstrate long-term positive impacts on child or family functioning or recidivism. The money used to support these programs was then redirected into the statewide MST initiative.

In 2005, CSSD spent approximately $6.4 million to provide MST services to court-involved youth referred by juvenile probation departments. Of this, approximately $6 million was funded by a state appropriation through the state Office of Policy and Management; approximately $200,000 was funded by a Federal Edward Byrne Memorial Justice Assistance Grant (JAG); and approximately $129,000 was provided

Figure 6. Connecticut MST 2005 Funding by Source



Source: Program Data

through Federal Medicaid funds. Since the program was originally funded in 2003, the portion of Federal dollars supporting the program has varied considerably, from between $90,000 to $700,000 annually. The specific breakdown of Federal funds is as follows: $90,000 in FY 03–04; $700,000 in FY 04–05; $204,000 in FY 2005–06; and $125,000 in FY 06–07 (expected). These fluctuations are attributable to changes in the amount of Federal funding available through the Byrne and Juvenile Accountability Block grants. See Figure 6 for a breakdown of 2005 program funds.

Collaboration

CSSD contracts with community-based, private providers through a competitive bidding process to deliver MST services throughout the state. CSSD and the state Department of Children and Families, which also contracts for MST services for its juvenile justice population, have a Memorandum of Agreement (MOA) to co-purchase Quality Assurance (QA) services for all MST providers who contract with either CSSD or DCF. CSSD and DCF blend $500,000 and $250,000, respectively, for QA services for MST in Connecticut. While CSSD and DCF maintain separate service contracts for their MST teams (CSSD has 15 teams while DCF has 10 teams), the MOA requires the two agencies to use uniform language for setting service contract expectations with MST providers using uniform fiscal reporting documents.

2005 Program Funding

$6,082,859	**State Government: Court Support Services Division of the Judicial Branch**
$ 204,605	**Federal Government: Department of Justice – Juvenile Assistance Grant**
$ 129,093	**Medicaid**
$6,416,557	**Total Program Funds**

Crossroads, Summit County, Ohio

Program Information

Crossroads was originally established in 1999 as a drug court, and began mental health treatment integration in February of 2003. Collaboration between involved agencies has been a strong component of the court from its inception. Collaboration efforts included the formation of a 40-member advisory board that was involved in planning and conceptualization of the court. Crossroads serves all youth ages 12 to 17 residing in Summit County who have a major affective disorder, severe posttraumatic stress disorder, psychotic disorders, or who have co-occurring substance use disorders. Youth whose only mental health diagnosis is conduct disorder, oppositional defiant disorder, or ADHD are excluded along with youth who qualify for developmental disability services. In addition, the court excludes youth with very serious felonies and youth with previous convictions or current charges for drug trafficking and youth with gang involvement. Referrals are made to the court post-adjudication. However, if youth successfully complete the program, their admitting charge and any related probation violations are expunged from the youth's record. Youth remain in Crossroads for a minimum of one year. Eighty-eight youth completed the program in 2005.

Youth are assessed with the court psychologist's Structured Pediatric Psychosocial Interview, the Diagnostic Interview Schedule for Children–Voice Version, Ohio Scales, and the Global Risk Assessment Device. The court typically relies on the diagnoses provided by community providers. Community substance abuse and mental health providers use numerous assessment instruments to make their diagnoses. Mental health assessment and treatment is available primarily through Child Guidance and Family Solutions (community provider). However, youth and their families have the option of choosing any community treatment provider. Some Crossroads participants receive Integrated Co-Occurring Treatment (ICT), which is a pilot project characterized by very intensive in-home treatment that is administered over the course of 3 to 4 months. Each counselor carries a very small caseload, typically three to four youth at a time. Those deemed by the Court's suitability committee or treatment team to be most in need of home-based services are referred to the ICT supervisor for consideration and eligibility for ICT services. Crossroads probation officers serve as case managers and are responsible for community supervision of participating youth.

Because the court is post-adjudication, it is able to impose sanctions (electronic monitoring, loss/lessening of curfew, suspension of driver's license, residential mental health treatment, or detention time) on both the youth and parents in the event of noncompliance. However, the court emphasizes the use of incentives to encourage compliance.

Figure 7. Crossroads, Summit County, OH 2005 Funding by Source

Source: Program Data

Funding Information

The Crossroads program is funded through a combination of sources. In 2005, the majority of support for the program came from the state of Ohio's Reasoned Equitable Community and Local Alternatives to Minors (RECLAIM). Other support was provided by Summit County through its general fund, as well as a small grant from a local private foundation. The total amount of funds supporting the program is 2005 was $553,294. Funds are used primarily to support Crossroads staff and a subcontract for ICT services. See Figure 7 for a breakdown of 2005 program funds.

Collaboration

The Court subcontracts with a local social service agency for ICT services for youth participating in the Crossroads program. Other providers also provide services to youth in the Crossroads program.

2005 Program Funding

$435,194	**State Government: Department of Youth Services - RECLAIM**
$113,100	**Local Government: Summit County**
$ 5,000	**Other: Local Foundation**
$553,294	**Total Program Funds**

The Family Integrated Transitions Project, Washington

Program Information

The Family Integrated Transitions Project (FIT) is a re-entry program specifically designed for juvenile offenders with co-occurring mental health and substance use disorders. Eligible offenders are identified at intake in the state's juvenile correctional facilities. The youth must be between the ages of 11 and 17 at the time of intake, have a substance use disorder, meet mental health criteria (a current Axis I disorder or be prescribed psychotropic medication, or have demonstrated suicidal behaviors in the last 6 months), have 4 months remaining on their sentence and reside in one of the active service areas.

The key goals of the program include:

- Lower the risk of re-offending
- Improve the youth's educational level and vocational opportunities
- Connect youth with appropriate community-based services
- Achieve abstinence from use of controlled substances and alcohol
- Improve mental health and stability of youth
- Increase pro-social behavior
- Reduce criminal recidivism

For youth enrolled in the FIT program, services begin 2 months prior to release to ensure engagement and to strengthen community supports. The program emphasizes both family and community involvement and takes a strengths-based approach to treatment. To promote family and community involvement, services are provided in the youth's home and community. In addition, FIT therapists are on call to respond to crises.

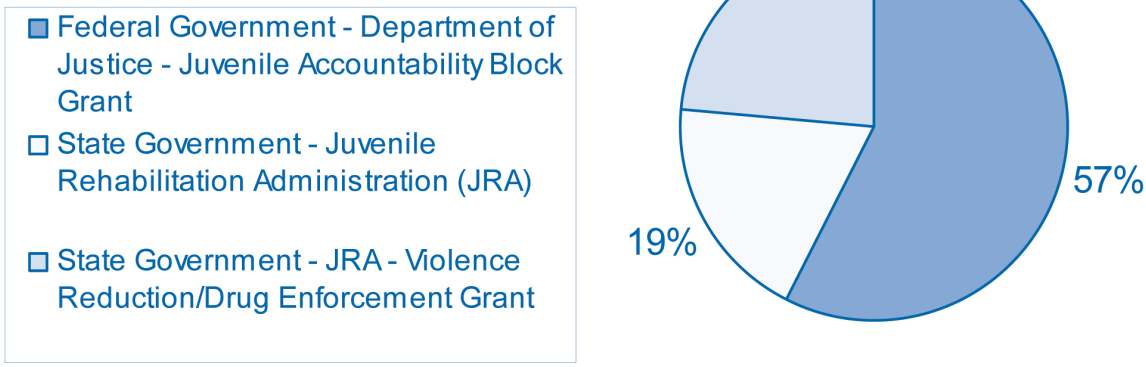
The treatment approach used with the FIT program encompasses an ecological, family-centered approach. The focus is on improving the psychosocial functioning of youth and promotes a parent's capacity to monitor the youth. The emphasis is on working with the youth in the context of the youth's natural environments of home, school, and community, modeled after Multi-Systemic Therapy. Specific interventions provided include Dialectical Behavioral Therapy and Motivational Enhancement.

The FIT program is administered by the state Juvenile Rehabilitation Administration (JRA). The program operates in four counties in the state, including King County (Seattle). In 2005, approximately 40 youth were served statewide by the FIT program.

Funding Information

Initially, when the program was established in 2000, it was supported entirely with funding from a Federal Juvenile Accountability Block Grant (JABG). As the JABG funds began to decrease, the Washington state legislature replaced the reduced JABG funding with

Figure 8. Family Integrated Transitions Project 2005 Funding by Source



Source: Program Data

state dollars. Currently, the program is supported by a JABG grant and state funds from the Department of Social and Health Services (DSHS)-Juvenile Rehabilitation Administration including general funds as well as a state Violence Reduction/Drug Enforcement grant. See Figure 8 for a breakdown of 2005 program funding.

Collaboration

There are no interagency agreements at the state or local level that support funding for this program. All program funds are provided by JRA. JRA does contract with the University of Washington for program oversight. In addition, JRA contracts with individual community treatment providers in the four local areas for FIT services.

2005 Program Funding

$410,839	**Federal Government: Department of Justice – Juvenile Accountability Block Grant**
$134,170	**State Government: Juvenile Rehabilitation Administration**
$168,991	**State Government: Juvenile Rehabilitation Administration – Violence Reduction/Drug Enforcement Act**
$714,000	**Total Program Funds**

Section Three: Analysis of the Findings

In this section, we provide a synthesis of the survey findings featured in the previous section and a broader context for understanding the challenges these programs face in serving justice-involved youth with mental health disorders. First, we look collectively across all the programs to extract the major cross-site findings and lessons learned that may be instructive to the field. The data and perspectives presented are derived from the responses of the seven programs to our survey. We conclude by identifying key funding issues and directions for the field to consider as it seeks to meet the mental health needs of youth involved with the justice system in a proactive, systematic, and comprehensive fashion. This final section draws on the findings from our research as well as policy perspectives and recommendations of other experts in the field.

1. Cross-Site Funding Analysis and Lessons Learned

Our survey asked programs to describe their funding strategy, including what sources were used to start their programs and the current sources and amounts of funding that support their programs. Table 2 presents a cross-site view of funding for the programs featured in this report. The table arrays each of the seven programs and identifies the total funding and the dollar value and percentage for each of the major funding sources. To foster a high-level view, we have categorized the government agency that administers the funding by its primary mission (e.g., mental health or juvenile justice) and have aggregated funds from the same source.

Five major findings emerged from the cross-site funding analysis:

1. The juvenile justice system currently shoulders the primary responsibility for funding mental health services for youth in its care. For five out of seven of the initiatives, juvenile justice agencies at the Federal, state, or local levels provide between 96 and 100 percent of funding for mental health services targeted to youth in the juvenile justice system. Only one initiative, the Texas Special Needs Diversionary Program, has a funding partnership involving both state mental health and juvenile justice departments, where, in fact, mental health funding ($3.9 million) is more than twice the amount of juvenile justice system funding ($1.9 million). The other exception is Bernalillo County. In this model, the Community Mental Health Clinic operates in close programmatic and geographic partnership with the detention center; however, the major funding for the Clinic comes from the County and Medicaid.

Going forward, Connecticut expects the mental health system to become a source of support for its MST initiative for court-involved youth. In January 2006, Connecticut established the Connecticut Behavioral Health Partnership to administer Federal and state mental health dollars for children and adults. The Partnership has established reimbursement rates for MST, and programs funded by the Court Support Services Division are preparing to seek reimbursement through this funding mechanism.

2. Federal grant funding currently plays a minimal role in most of the programs we reviewed. Only two programs reported Federal grant funding as part of their support: Connecticut MST for Court-Involved Youth and Washington's Family Integrated Transition Project. In both these instances, Federal funding originates with the Department of Justice. Specific funding programs include the Juvenile Accountability Block Grant (JABG) administered by the Office of Juvenile Justice and Delinquency Prevention and the Edward Byrne Memorial Justice Assistance Grant (JAG) administered by the Bureau of Justice Assistance. Both Connecticut and Washington

Table 2. Source and Amount of Funding for Programs Surveyed

Source of Funding	Bernalillo County Juvenile Detention Center Children's Community Mental Health Clinic		Cook County Juvenile Court Clinic		Crossroads, Summit County Ohio		Family Integrated Transitions Project, Seattle Washington		Washington State Integrated Treatment Model in Juvenile Rehabilitation Facilities		Texas Special Needs Diversionary Program		Connecticucut MST Initiative for Court-Involved Juveniles	
Total Funding	$171,778	100%	$2,041,786	100%	$553,294	100%	$714,000	100%	$400,053	100%	$6,759,966	100%	$6,416,556	100%
Federal Government														
Mental Health														
Juvenile Justice							$410,839	58%					$204,604	3%
Other														
State Government														
Mental Health											$3,935,204	58%		
Juvenile Justice					$435,194	79%	$303,161	42%	$400,053	100%	$1,974,033	29%	$6,082,859	95%
Other														
Local Government														
Mental Health														
Juvenile Justice			$1,973,789*	97%										
Other	$94,028	55%			$113,100	20%								
Client-Specific Reimbursement														
Medicaid	$75,576	44%									$850,729	13%	$129,093	2%
Third Party Insurance	$1,230	1%												
Program Fees	$944	1%												
Foundations														
National			$67,997	3%										
Local					$5,000	1%								

*Cook County's Local Juvenile Justice Funding includes the estimated annual value of outstationed staff ($535.000)

reported that Federal grant support for their programs has actually decreased over time. For example, in Connecticut, Federal grant funding has declined from $700,000 in 2004–05 to $204,000 in 2005–06 to an anticipated $125,000 in 2006-07—reportedly due to changes in the amount of Federal dollars available through JABG and JAG grants. None of the programs identified Federal grant funding from the Substance Abuse and Mental Health Services Administration within the Department of Health and Human Services as a current source of support for their initiatives.

3. Program leaders have utilized diverse financing strategies to support the start up and operations of their initiatives. Programs reported a range of financing strategies used to start and operate their programs, suggesting that there is no single set of resources available for this purpose, nor is there one best way to secure funding. The various strategies that were utilized are highlighted below:

- **Redirection of Existing Funding.** In Connecticut, the state invested $6.5 million in state funding to support a statewide, evidence-based Multi-Systemic Therapy Initiative, by terminating contracts for community-based programs that were not demonstrating positive long term impacts on child and family functioning or recidivism. In the State of Washington's Juvenile Rehabilitation Administration's facilities, portions of the ongoing operational budget were carved out to support the Integrated Treatment Model and the Family Integrated Transitions Project.
- **New Appropriations.** In Texas, the Legislature appropriated new funding to both the mental health and juvenile justice agencies with the specific intent of implementing an interagency approach to preventing the removal of juveniles from their home or further penetration into the juvenile justice system.
- **Grants from Managed Care Organizations.** In Bernalillo County, the Juvenile Detention Center's Children's Mental Health Clinic start-up strategy included securing grants from three managed care organizations, reassigning staff from the detention center to the Clinic, and securing donated building space. While no longer providing grants to support the Clinic, the now combined managed care entity continues to be a critical partner to the Clinic through its role in ensuring third party reimbursements.
- **Foundation Funding.** In Cook County, the John D. and Catherine T. MacArthur Foundation provided major support for the research and development phase of the Juvenile Court Clinic. Since the Clinic's opening in 2003, the MacArthur Foundation has continued to be a source of support by funding various specific projects (e.g., program evaluation, community based mental health resource database, and a forensic post doctoral fellowship position).
- **Funding from Multiple Sources.** All but one of the programs have packaged two or more funding sources to support their initiatives. Combinations include government funding and Medicaid; government and foundation funding; and funding from two levels of government.

4. Only three programs rely on Medicaid as a source of support. Three programs receive Medicaid reimbursement for the mental health services they directly provide to eligible youth. Medicaid makes up 44 percent of Bernalillo County Detention Center's Community Mental Health Clinic funding as compared to 13 percent of Texas' Special Needs Diversionary Program funding and 2 percent of Connecticut's MST Initiative for Court-Involved Youth.

5. Whether a program is generated at the state or local level influences the funding mix. Of the seven initiatives, three are local county models and four are initiated by state government. Models generated locally are:

- Bernalillo County Juvenile Detention Center's Community Mental Health Clinic
- Cook County Juvenile Court Clinic
- Crossroads, Summit County Ohio

State initiated models are identified below, along with a description of their geographic reach:

- Washington State Family Integrated Transitions Model—implemented by Juvenile Rehabilitation Administration (serves youth transitioning from the institution to the community in four counties)
- Washington State Integrated Treatment Model in Juvenile Rehabilitation Administration Facilities (serves all youth in JRA facilities)
- Texas Special Needs Diversionary Program (16 programs impacting 19 local juvenile probation departments across the state)

- Connecticut MST for Court-Involved Juveniles (15 MST teams across the state)

All four of the state generated initiatives are funded by state government with the portion of state funding ranging from 42 to 100 percent of the total. The state initiatives are the only ones to report Federal grant funding as well. The three local initiatives all receive local government support but only one program is funded by state government. These findings suggest that it may be more strategic to advocate for a state level initiative in order to maximize access to state and Federal resources and develop a program with greater geographic reach.

As part of the survey, the NCMHJJ asked respondents to identify the top funding challenges they have encountered in administering their programs, along with lessons learned that would be helpful to others across the country attempting to develop a similar program. The programs cited the lack of stable, sustainable, and reliable funding streams as the overarching challenge to effectively serving youth with mental health disorders involved with the justice system. Programs raised a number of concerns about the adequacy of funding to support program operations, quality assurance activities, and evaluation. Highlighted below are the major themes that were raised by two or more of the programs:

- **Gaps in Coverage for Children.** Programs cited limited payment sources and funding for children and adolescents who are neither eligible for Medicaid nor covered by private insurance—both when youth are enrolled in the program (noted by Bernalillo County) and after they have transitioned from the program (cited by Washington's FIT program).
- **Critical Services in the Continuum Not Supported by Current Funding.** Nearly all programs identified a service they thought was critical to the program but was not supported through available funding. While specific service gaps varied by program model, funding to support aftercare services was the most frequently identified gap, noted by Connecticut, Washington's FIT, and the Crossroads program. Texas identified substance abuse services as the major gap and the need for integrated treatment approaches to better serve the over 50 percent of youth in its care with co-occurring substance abuse and mental health disorders—a gap that Crossroads and Washington State are addressing by targeting their initiatives to youth with co-occurring disorders.
- **Insufficient Resources for Quality Assurance and Program Evaluation.** Connecticut and Washington both underscored the challenge of securing funding for quality assurance and program evaluation and the importance of these functions for the long term viability of the program. The survey respondent from Washington indicated that "quality assurance and research/measurement components are critical to the success of evidence-based programming. Funding for these pieces upfront would allow planning and implementation of quality assurance processes and measurement tools at the front end of the model implementation." Similarly, Connecticut reported: "Continued investment in program evaluation is critical to program success and yet are the most difficult dollars to obtain…." and recommends that programs "develop a plan to track and monitor outcomes from the beginning in order to make necessary changes and inform funders of the results of their investments."
- **Administrative Complexities Related to Billing, Contracting, and Fiscal Reporting.** Three programs noted administrative challenges related to funding along with potential solutions. Bernalillo County reported billing and reimbursement challenges resulting from the need to interface with three managed care organizations—difficulties that have been alleviated by the three entities merging into one managed care organization. In Connecticut, two state agencies—Court Support Services Division and the Department of Children and Families —contract for MST services for different populations, which has created administrative complexities for MST providers. While each department maintains their own contracts with MST providers, the departments have agreed to use uniform language for setting service contract expectations with MST providers and to require uniform fiscal reporting documents. Lastly, for programs that are part of larger institutional settings, Washington State suggests that others "set up the tracking of expenditures in the beginning so that accounting information specific and exclusive to the program can be quickly and accurately retrieved."

- **Resource Constraints Limit Program Expansion and Replication.** Neither Texas' Special Needs Diversionary Program nor Washington's Family Integrated Treatment Program cover the whole state. Similarly, Cook County Juvenile Court Clinic, a locally initiated program, would like to disseminate its approach to other jurisdictions but requires funding to do so.
- **Need for More Diversified Funding.** Programs recognize the need to go beyond their established funding streams and seek alternative sources of public sector and foundation support. Greater diversification is viewed as one important key to sustainability and to securing funds to address the majority of funding challenges outlined above. Actively pursuing partnerships with other organizations—such as mental health and juvenile justice government agencies, the courts, foundations, and managed care organizations—that could potentially provide funding or other resources is an approach to ensuring the continued existence and growth of programs.

2. Proposed Directions for the Field

Based on the survey results and a targeted review of relevant policy research, we have identified five proposed directions for the field to consider under the broad rubric of funding. These provide a framework for actions that programs can take as they seek to initiate, operate, replicate, and bring to scale interventions that best meet the needs of justice-involved youth with mental health disorders.

1. Greater Interagency Collaboration and Funding Commitment is Required While the juvenile justice system has responsibility for youth in its care, there is growing awareness of the need to develop interagency funding and service delivery strategies to more effectively respond to youth with mental health disorders. Collaboration is one cornerstone in the *Blueprint for Change*. In the programs we surveyed, however, the juvenile justice system was identified as the primary funder, suggesting a need for stronger partnerships and funding commitment among child-serving systems. While the primary systems are juvenile justice and mental health, the full range of agencies involved extends to include the education, substance abuse, health care, and child welfare systems. While it may be more expedient for a single system—like juvenile justice—to develop and fund its own program to serve the population, multiple systems share responsibility for these youth, have programmatic expertise, and should be engaged in the process of developing the service response, desired outcomes, and funding strategy.

2. All Potential Financing Strategies Should be Considered The programs we surveyed use a variety of financing strategies to support their service approaches for justice-involved youth with mental health disorders. While there is clearly no one best approach, programs should take ample time to comprehensively review potential financing strategies and incorporate all viable approaches into their financing plan. Further, programs supported on grant funds should pay early attention to identifying long-term funds to sustain the program once the grant funding ends. The Research and Training Center for Children's Mental Health at the University of South Florida recently produced *A Self Assessment and Planning Guide: Developing a Comprehensive Financing Plan,* which sets forth a range of financing strategies to help states and communities support system of care approaches for children and adolescents with, or at risk of, serious emotional disturbances and their families (Armstrong et al, 2006). These strategies are highly relevant to more targeted initiatives focused on justice involved youth with mental health disorders. The *Self Assessment and Planning Guide* provides useful guidance on the following topics: 1) identification of current spending and utilization patterns across agencies; 2) realignment of funding streams and structures; 3) financing of appropriate services and supports; 4) financing to support youth and family partnerships; 5) financing to improve cultural and linguistic competence and reduce disproportionality in care; 6) financing to improve the workforce and provider network; and 7) financing for accountability.

Under the second topic – realignment of funding streams and structures – the Research and Training Center outlines a number of financing strategies that are particularly germane to this paper:

- Utilize Diverse Funding Streams
- Maximize Federal Entitlement Funding
- Redirect Spending from Deep-End Placements
- Support a Locus of Accountability for Service, Cost, and Care Management for Children with Intensive Needs
- Increase Flexibility of State and/or Local Funding Streams and Budget Structures

- Coordinate Cross-System Funding
- Incorporate Mechanisms to Finance Services for Uninsured and Underinsured Children and Families

Based on our survey and knowledge of programs aimed at serving justice-involved youth with mental health disorders, some of the recommended financing strategies are being utilized, but many are not and are worthy of further consideration.

3. Constraints within Funding Streams Should Be Removed In addition to developing interagency financing plans, the field should continue efforts to critically analyze each relevant state and Federal funding stream, identify barriers that reduce accessibility to these funds, and develop strategies to address these barriers. Work in this area will increase the resources available from existing funding streams to fund mental health services for justice-involved youth.

There are two recent examples of positive actions to modify broadly defined funding streams to better serve our target population. Effective 2005, the Office for Juvenile Justice and Delinquency Prevention's (OJJDP) Juvenile Accountability Block Grant, which gives states latitude to fund a variety of goals, was modified to include mental health screening and intervention as a new priority area. (Koppelman, 2005). In addition, OJJDP and the Center for Mental Health Services (CMHS) have collaborated to increase juvenile justice system involvement in systems of care funding. Under this interagency agreement, OJJDP has provided funds to the CMHS technical assistance grantee to promote inclusion of youth with mental health needs in the juvenile justice system in other systems of care. (Cocozza & Skowyra, 2000).

Medicaid is a major source of funding for mental health and related support services for youth, and barriers limiting access to Medicaid for youth involved in the juvenile justice system have been well documented. (Bazelon Center for Mental Health Law, 2001; Koppelman, 2005; and Kamradt 2002). Under 42CFR, 436.1004(a), Federal financial participation is not available to support Medicaid services for individuals who are inmates of detention centers, jails and correctional facilities. The Federal restriction does not require states to terminate eligibility upon incarceration, only to eliminate payments for services rendered during the period of incarceration. But according to the Bazelon Center for Mental Health Law, most states opt to terminate enrollment. The result, as described by Koppelman (2005), is that "youth experience an interruption in coverage upon release, having to reapply for Medicaid and wait an average of 45–90 days for reinstatement. This is a particular problem for youth with schizophrenia, bipolar disorder, and other conditions who require medication to remain functional."

In addition to not terminating a youth's Medicaid eligibility while in detention or a correctional facility, some states have adopted innovative interpretations of Medicaid regulations to maintain Medicaid funding for youth in the juvenile justice system (Kamradt, 2000). These include:

- **Committing youth to non-juvenile justice, privately owned and operated facilities, like Residential Treatment Centers (RTC's).** States can contract with not for profit agencies of any size if they are not run by the juvenile justice agency. Medicaid will pay if the therapeutic facility or the services provided by the facility are covered under Medicaid law. For small residential facilities with less than 16 beds, for example group homes, allowable services can be covered by Medicaid, but Medicaid will not pay for room and board.
- **Continuing Medicaid without Federal financial participation.** This saves the state money by allowing the child to access services at reduced Medicaid rates, and reduces the administrative burden of terminating and reactivating cases. Massachusetts initiated this policy by facilitating an agreement between the Department of Youth Services (DYS) and the Department of Public Welfare (DPW) to provide Medicaid to all incarcerated youth. DYS reimburses DPW for all youth who are found to be ineligible for FFP.

4. Knowledge about Funding Streams and Promising Practices Should be Increased Planners formulating mental health and juvenile justice programs need to be well versed in high-probability funding streams and effective financing strategies utilized by promising programs across the country. The complexity of different types of government funding, including entitlement programs, block grants, and discretionary grants, which each have distinct purpose, scope, eligibility requirements, and allocation methodology, makes this particularly challenging. In its analysis of Federal programs that fund services to assist transition-age youth with serious mental health conditions, the Bazelon Center, for example, identified 57 potential funding streams that are run by 20 or more different agencies in

nine departments of the Federal government (Koyanagi et al., 2005). To determine how best to "mix and match" and most effectively utilize Federal, state and local funding, the Bazelon Center recommends that states and localities form teams of staff from relevant agencies and charge them with becoming experts on Federal funding (Koyanagi, Boudreaux, & Lind, 2003). This is solid advice that should be heeded by interagency collaborations responsible for mental health and juvenile justice initiatives.

From NCMHJJ's experience in developing the *Blueprint for Change*, we know that there are many programs across the country that have successfully developed financing strategies to support interventions at all critical intervention points. The field would benefit from an ongoing mechanism to share information about financing strategies and funding portfolios used to support the programs. Focusing on how evidence-based practices are funded in different states would be of particular value.

5. Funding for Evaluation Should Be a Priority There are large numbers of youth in the juvenile justice system for whom services are not available to identify and respond to their mental health challenges. Developing new services, maintaining high-quality programs, and taking initiatives to scale requires an infusion of resources. In order to be in a strong position to advocate for additional investments, state and local programs will need data on program results and unmet needs. The programs we surveyed clearly understand the importance of evaluation, but noted this as a function that was frequently underfunded. Incorporating evidence-based practices into state and local approaches aids with evaluation, but programs still require resources to measure their results. A challenge for the field, therefore, is to ensure that sufficient funds are allocated to build a data-driven case for continued funding and program expansion.

Section Four: Summary

This survey provides us with information about the funding portfolio of seven programs identified in the *Blueprint for Change* as promising practices for serving justice-involved youth with mental health disorders. Findings reveal that the majority of program funding is from the juvenile justice system and originates with state or local government. While many of the programs have formed service delivery partnerships, the paucity of interagency funding arrangements is noteworthy. Programs face numerous funding challenges, most notably achieving and sustaining a funding portfolio that is sufficient to ensure high quality programming and support an outcome-focused evaluation strategy. In addition, programs are not funded sufficiently to bring the promising practices to scale. Additional research is required to determine if the survey findings are idiosyncratic or representative of other programs in the field. However, because many of the findings uncovered by this survey are recognized as critical issues and directions by other policy researchers in the field, it is believed that the proposed directions are well founded can serve as a useful organizing framework for future action.

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