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A GUIDE TO JUVENILE DETENTION REFORM

Bernalillo County Mental Health Clinic Case Study

Juvenile Detention Alternatives Initiative

A PROJECT OF THE ANNIE E. CASEY FOUNDATION

Acknowledgments

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Introduction

It is one of the most complex challenges facing our nation’s juvenile courts, probation agencies and detention centers: How to provide effective mental health treatment for youth involved in the juvenile justice system? Particularly vexing is how to provide high-quality mental health care for youth entering detention (or being placed into detention alternatives) and then ensure that the care continues uninterrupted after youth exit detention supervision.

This report examines how one jurisdiction — Bernalillo County, New Mexico — has taken extraordinary steps to address these detention-related mental health challenges first by ensuring Medicaid eligibility for detained youth and then by establishing a licensed free-standing community mental health clinic adjacent to its detention facility. Now 10 years old, Bernalillo’s mental health clinic has provided services to thousands of court-involved youth. Though costly and fraught with complexity, the clinic has proven a useful component in Bernalillo’s notable successes reducing detention populations and promoting success for court-involved youth. It offers a valuable case study for juvenile justice officials everywhere who are interested in improving mental health services for youth in their systems.

The report begins by briefly reviewing the mental health challenge facing juvenile courts generally and detention agencies specifically in providing effective mental health services for court-involved youth.

Following that is an overview of the Bernalillo County JDAI program — how it started, what strategies it has employed and how its leaders came to identify mental health as a core challenge requiring an aggressive and creative response.

Next, the report details the steps in the evolution of Bernalillo County’s mental health strategy, including the development of improved mental health services for detained youth, the pursuit of reforms to ensure the continuity of Medicaid eligibility for detained youth, and finally the creation, licensing and initial financing of the mental health clinic.

The report then provides a description of Bernalillo’s new mental health clinic — including its programs and services, clientele, staffing and financing. The sixth chapter examines the clinic’s impact, reviewing available data and discussing the various mechanisms through which the clinic is advancing the goals of detention reform and of the juvenile justice system generally.

The final chapters of the report review the lessons learned from Bernalillo’s experience with mental health, including discussion of: (a) the issues and challenges Bernalillo has faced in creating, sustaining and ensuring the effectiveness of the clinic; (b) the key questions other jurisdictions should review when considering whether to replicate the Bernalillo clinic model; and (c) the lessons emerging from Bernalillo’s experience about the role of mental health treatment in detention reform that will be useful for all jurisdictions, whether or not they elect to follow Bernalillo’s lead in creating an independent mental health clinic.

Understanding the Mental Health Challenge for Juvenile Detention Reform

Available research suggests that two-thirds to three-fourths of youth confined in juvenile detention or youth corrections facilities nationwide suffer with one or more mental health (and/or substance abuse) conditions, and roughly one-fifth suffer with severe mental health symptoms that significantly limit their capacity to function in daily life, follow rules, succeed in school and/or avoid serious behavioral problems that can result in arrest and referral to juvenile court.¹

Substantial evidence also shows that mental health treatment can, if designed well and delivered effectively, substantially reduce offending by delinquent and high-risk youth. A vast body of research has shown that evidence-based treatment models like Functional Family Therapy and Multisystemic Therapy — plus a handful of other proven modalities — are more effective with delinquent and substance abusing teens than conventional services, and result in large savings for taxpayers. A variety of state and local programs providing enhanced mental health treatment have also shown far better results (and lower costs) than conventional juvenile justice approaches. Examples include Ohio’s Behavioral Health/Juvenile Justice initiative,² “wraparound” programs in Milwaukee and Washington State,³ and Texas’s Special Needs Diversionary Program.⁴

However, the evidence is also clear that many court-involved youth are not receiving the kinds of responsive, high-quality mental health services they need. For instance, less than 5 percent of high-risk juvenile offenders who might benefit from evidence-based treatment strategies currently participate.⁵ Among youth in detention, the first-ever Survey of Youth in Residential Placement, published in 2010, found that just 30 percent reported receiving any counseling services.⁶ Even among detained youth with above-average symptoms for anger, anxiety, suicidal ideation, hallucination and depression/isolation, fewer than half reported receiving counseling services. Likewise, just 28 percent of detained youth — and less than one-third of those using drugs daily or several times per week before their arrests — reported any substance abuse counseling or treatment while detained.⁷

Meanwhile, many youth are being processed and prosecuted in the juvenile justice system for low-level misbehavior that would be better handled by other agencies, such as community mental health, child welfare and schools. The U.S. Government Accountability Office has reported that in just 30 large counties nationwide (home to 16 percent of U.S. children), more than 9,000 young people, mostly adolescent boys, were placed into juvenile custody in 2001 for the sole purpose of obtaining mental health treatments.⁸ In many cases, parents asked police to arrest their children, voluntarily relinquishing custody in order to access mental health services that were unavailable to them due to a lack of services in their local schools and community mental health systems, or due to lack of coverage through Medicaid or private insurance to pay the cost.

Thomas Grisso, a leading expert on mental health problems facing youth in the juvenile justice system, has explained that “During the 1990s, state after state experienced the collapse of public mental health services for children and adolescents and the closing of many — in some states, all — of their residential facilities for seriously disturbed youths. The juvenile justice system soon became the primary referral for youths with mental disorders.”⁹ In 2004, a U.S. congressional committee investigation found that in just the first half of 2003, nearly 15,000 youth were incarcerated in juvenile facilities awaiting mental health treatment. The committee report estimated that 2,000 youth each day are in juvenile custody awaiting mental health treatment.¹⁰

Funding rules also present an impediment to providing responsive treatment for many youth with mental health needs. For instance, funding for case management and nonresidential treatment can be difficult to support, whereas more expensive and less-effective residential facilities are more easily funded. Funding rules can also create incentives for system personnel to diagnose youth, which enables providers to claim reimbursements for services provided but can have lasting negative consequences for youth. Federal law prohibits the use of federal Medicaid moneys to fund health or mental health services for incarcerated youth or adults. In many states, youth are routinely terminated from Medicaid coverage when they enter custody — even though federal rules allow and even encourage states to *suspend* rather than *terminate* coverage whenever a Medicaid recipient is placed in an institution. “When youth lose their Medicaid enrollment while in confinement, they must reapply for benefits upon their release, a process which may take up to 90 days or longer to complete,” explained a national task force on juvenile re-entry in 2009. “This delay seriously threatens successful reintegration to the community and often results in long delays in obtaining vital treatment, medication, and services at a time when they are most needed. Gaps in services significantly increase the risk of reoffending and recommitment to an institution.”¹¹

These financing challenges can be especially difficult at the detention phase of the process. In a recent survey of local juvenile detention facility administrators nationwide, half reported that their facilities disenroll youth from Medicaid upon admission. In addition, 81 percent of the surveyed facilities provide youth with only a one-day supply of medication upon release, and less than half the facilities provide a refill prescription for youth who are receiving psychiatric medications.¹² These practices make it difficult for court authorities (or parents) to ensure continuity of medications and treatment following release from detention and/or placement into a detention alternatives program.

Clearly, given these realities, mental health presents a pivotal issue for the success of many youth — and for the overall success of juvenile detention reform. Bernalillo County, the focus of this publication, has addressed these issues as aggressively as any jurisdiction in the nation.

Creating and operating a free-standing mental health clinic has required a substantial investment of time and resources in Bernalillo County, and it is based on a unique partnership with state government and with Medicaid managed care agencies. Thus, the clinic model will not be viable for many jurisdictions. However, the lessons emerging from Bernalillo’s experience are relevant for all jurisdictions seeking to improve their capacity in meeting the mental health needs of court-involved youth.



Bernalillo — Becoming a Model JDAI Site

Bernalillo County’s participation in JDAI began in 1998, soon after Tom Swisstack became the county’s detention director. Early in his tenure, Swisstack and two of the county’s juvenile judges attended a JDAI workshop led by Bart Lubow, who leads the JDAI initiative for the Annie E. Casey Foundation.

Even before they attended the workshop, Swisstack and the judges were eager to bring down the county’s detention numbers. Designed to house just 78 young people (even after two 15-bed expansion projects in 1994 and 1996), the Bernalillo detention facility was badly overcrowded, reaching a peak of 143 youth in April 1998. Swisstack accommodated the extra bodies only by installing stackable bunk beds, which made normal programming impossible and heightened tensions inside the facility for staff and youth alike. Looking forward, county leaders recognized these arrangements were untenable, forcing them to consider a third multimillion dollar expansion project.

Swisstack and the judges were already familiar with JDAI, because together they had prepared Bernalillo County’s unsuccessful application to become a pilot JDAI site five years earlier. (Swisstack served as an associate director of detention in the early 1990s, then left in 1994 to serve as mayor of an Albuquerque suburb before returning as detention director in 1998.) The Bernalillo group approached Lubow after the presentation, and he later agreed to provide seed funding for the county to study the JDAI pilot sites and plan its own detention reform campaign.



ABOUT BERNALILLO COUNTY Home to the city of Albuquerque, Bernalillo County is the largest population center in New Mexico. With a population of 660,000, it is home to roughly one-third of the state’s population. Nearly half (47.9 percent) of county residents are Hispanic, and about two in five (41.5 percent) are non-Hispanic whites. Native Americans, African Americans, and Asians comprise 4.8 percent, 3 percent and 2.3 percent of the county population, respectively. One-fourth of the county’s population is under age 18. The county’s poverty rate of 15.6 percent is well above the national average (13.8 percent), while per capita income of \$26,143 is slightly below the national average (\$27,334).

Source: All data from the 2010 U.S. Census.



Under Swisstack's leadership, Bernalillo moved aggressively to adopt many JDAI core strategies, including:

- a new risk-assessment instrument (RAI) that substantially reduced the number of youth admitted to detention;
- new procedures to promote attendance in court and reduce the number of youth detained on bench warrants for failure to appear in court;
- a new collaborative process — anchored by a daily meeting among stakeholders prior to each day's detention hearings — to explore all available options to minimize detention placements for youth referred to juvenile court;
- a new “expediter” hired to develop release plans for youth held for extended periods in detention and identify opportunities to speed their exits from detention;
- a new sanctions grid to reduce the use of detention as a sanction for noncriminal probation violations; and
- creation of two new detention alternative programs — a day reporting center and community supervision — staffed by employees reassigned from custodial positions inside the detention center.

In addition to these programmatic changes, Bernalillo's juvenile court underwent a noteworthy culture change after launching JDAI. As Tommy Jewell, then Bernalillo's presiding juvenile judge, explained in 2002, “We used to think that everybody is better off if this kid is locked in detention. But I think we've made a philosophical shift that in general, we now recognize that detention is not healthy or rehabilitative for kids, even if it is necessary in some cases [to protect public safety].”

Taken together, all of these JDAI-related changes allowed Bernalillo to rapidly reduce its daily population in locked detention. The headcount, which peaked at 143 in April 1998 and averaged 118 per day for all of 1998, declined steadily to 85 youth per day in 2001. Detention admissions for bench warrants and probation violations plummeted, average lengths of stay declined, and participation in detention alternative programs skyrocketed. The vast majority of Bernalillo youth placed into detention alternative programs both avoided rearrest and appeared in court as scheduled. Meanwhile, the county's overall juvenile arrest rates fell steadily.

Based on these successes, the county was able to close a 12-bed unit of the detention center in 2000, allowing Swisstack to reassign 12 staff away from custodial supervision inside the facility. (The bed reduction was especially impressive given the previous overcrowding in the facility just two years earlier, and the likelihood that — without detention reform — Bernalillo County would have been expanding the bed capacity, rather than contracting.) Then again in 2002, further population reductions allowed Swisstack to mothball another 15-bed unit, freeing up an additional dozen workers to work in detention alternatives and other program enhancements to sustain and deepen the reforms, and to maximize successful outcomes for court-involved youth.

DETENTION REFORM IN BERNALILLO COUNTY: HIGHLIGHTS OF SUCCESS

Since Bernalillo County launched its JDAI project in 1998, it has made noteworthy progress not only in reducing the unnecessary use of detention, but also in a wide range of other juvenile justice measures. Taken from a December 2011 report entitled *Smaller, Smarter, and More Strategic: Juvenile Justice Reform in Bernalillo County*, following are some of the highlights.

- **Less Use of Detention:** At the detention center, admissions have fallen 36 percent since 2000 and average daily detention population has fallen by 45 percent.
- **Successful Use of Detention Alternatives:** The county's two detention alternative program models (community custody and youth reporting center), serve more than 500 youth per year, many of whom would otherwise be detained. Success rates from these programs have improved in recent years, so that in FY 2011, 91 percent of youth participating in reporting centers and 95 percent of those assigned to community custody committed no new offenses while under supervision and attended court as scheduled.
- **Savings for Taxpayers:** Because detention alternatives cost far less than secure detention (\$33/day vs. \$285/day), Bernalillo's reforms have saved taxpayers millions of dollars. Specifically, county officials estimate that the detention alternatives saved county taxpayers \$4.7 million from FY 2004 to FY 2010, including \$946,000 in FY 2010 alone.
- **Less Youth Crime:** Since 2004, juvenile delinquency referrals have declined in every offense category, and the total number of youth referred to the juvenile probation department has fallen 28 percent.



Bernalillo's Mental Health Challenge

Though pleased by this rapid and encouraging progress, Swisstack and Bernalillo County's other juvenile justice leaders continued to seek other opportunities for reform. In particular, they grew increasingly concerned with one serious and unaddressed barrier to progress in detention reform: mental health.

Even before Swisstack took over as Bernalillo's detention director, the county had identified mental health as a major challenge. Indeed, under Swisstack's predecessor in the early 1990s, county leaders discussed the possibility of creating a specialized mental health wing in the detention center to serve court-involved youth with serious unmet mental health needs — an idea far-removed from the widely accepted purposes of detention nationally.

These plans never got off the ground, Swisstack recalls. Not only was no mental health unit created, he says, but the detention center never developed a strong treatment program. "The facility's two mental health staff weren't even degreed people," he says. "We weren't equipped to do treatment or heavy psychotherapy." The center added a third mental health treatment provider in 1996, when substance abuse counselor Rick Miera was hired using a grant funded through a local liquor tax. But even with Miera on board, Swisstack says, "kids weren't coming into our facility to get treatment, because we didn't have a strong treatment program."

By the time the JDAI program was initiated in the late 1990s, administrators and staff at the Bernalillo detention center, as well as probation officers and judges, all recognized that many of the youth referred on delinquency charges and many of the youth populating the detention center (often the most difficult detention cases) suffered with acute mental health conditions, substance dependency or both. Lacking hard data on the problem, Swisstack directed his staff in 1999 to study the mental health status of youth in detention. The results were striking:

- Eighty-five percent of youth passing through the detention center suffered with one or more mental health conditions.
- Sixty percent of the juvenile detainees should have been on behavior-modifying medication.
- In many cases, youth were arrested for behavior that was symptomatic of a mental health diagnosis.
- Youth with a mental health diagnosis were more likely to return back to detention than other youth.
- While in detention, youth were often cut off from medications and from relationships with supportive adults, including parents, family and therapists.
- Most of the youth being served in detention were either on Medicaid or were Medicaid eligible.

To address these gaps, Swisstack focused initially on expanding the scope and quality of mental health treatment services for youth inside Bernalillo’s secure detention facility, the Youth Services Center. Despite overwhelming needs, detained youth were receiving little mental health services or treatment prior to Bernalillo’s embrace of JDAI. The counselors employed by the detention center focused mainly on immediate crisis intervention for youth who acted out in the facility or displayed risks for suicide or severe symptoms of mental illness (such as bipolar disorder). The majority of youth entering detention had prescriptions for psychotropic medications, but many had diagnoses that seemed inappropriate, and the youth had scant access to psychiatric care or medication management while detained. Also, the detention center had no capacity to conduct thorough mental health assessments of detained youth, and staff were very limited in their capacity to develop mental health service or treatment plans, or to initiate longer-term treatment services for youth before completing their stays in the detention center.

In response, Swisstack introduced new job descriptions requiring that counseling staff in the detention center be licensed mental health or substance abuse therapists, and he hired new counselors with the capacity to formally assess mental health needs and develop treatment plans for detained youth. To pay the higher salaries of these new counselors, Swisstack reallocated funds within the detention center’s budget. “As staff people left, I brought in new people with deeper skills,” Swisstack recalls. “As a result, we were able to develop service plans for kids while they were inside the facility, and actually begin treatment.” Swisstack also forged a partnership with psychiatrists at the University of New Mexico to prescribe and monitor medications for detained youth.

According to Swisstack, the enhanced mental health services inside the detention center improved the county’s ability to stabilize mental health conditions and improve behavior among confined youth. As a result, the detention center became more effective in helping youth “clean up” for their 30-day appearance in front of the judge, and average detention stays declined as judges permitted increasing numbers of youth to exit the detention center on community supervision.¹³

Unfortunately, Swisstack and Miera recall, the behavioral improvements proved short-lived in many cases, as problems quickly resurfaced after young people left the detention center. Many youth were returning to detention after release, some of them repeatedly. “I think we were providing kids with excellent care inside the facility,” says Miera, “but only for a brief period of time. We weren’t able to connect

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DESPITE OVERWHELMING NEEDS, detained youth were receiving little mental health services or treatment prior to Bernalillo’s embrace of JDAI.

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our in-house treatment to ongoing treatment in the community, and once you let these kids slip, they lose momentum, and it becomes a revolving door.”

Despite the best efforts of detention staff, youth were often released from detention with no connection to mental health services in the community or to any physician for ongoing medication monitoring. Often, youth who needed mental health medications were unable to get psychiatric appointments in the community. The Bernalillo community suffered with an overall shortage of psychiatrists to serve behaviorally troubled adolescents, and many psychiatrists refused to serve Medicaid patients because of cost-reimbursement issues. The problem was so severe that “it could take three months for a kid to see a psychiatrist,” recalls county Juvenile Probation Chief Jeanne Masterson. “We had many kids who were being detained because they need services, but we couldn’t get them seen.” In addition, when detention staff tried to help the parents connect their kids to mental health services in the community, most parents were apprehensive or simply incapable of navigating government and medical bureaucracies.

For all of these reasons, Swisstack became increasingly convinced that a more ambitious strategy was needed to meet the mental health challenge. Providing mental health services inside the detention center would not be enough: youth also needed mental health services after they left detention.

As he explored options for addressing this need, Swisstack benefited from a fortuitous personnel coincidence. The detention center’s new substance abuse counselor, Rick Miera, was a state legislator. A leader in the legislature on issues involving youth and mental health, Miera proved an important ally for Swisstack’s efforts to expand mental health services for Bernalillo youth.

Swisstack and Miera met repeatedly throughout 1999 and 2000 to brainstorm solutions to the mental health challenge, and their discussions centered increasingly around the state-federal Medicaid program, which is the primary source of medical (and mental health) insurance coverage for the vast majority of youth detained or supervised by Bernalillo’s detention center. Bernalillo’s interest in Medicaid was fueled by the growing trend toward managed care. In New Mexico, three insurance companies had been tapped by state authorities to oversee vast Medicaid budgets with an incentive to invest in approaches that reduced long-term costs. Swisstack and Miera recognized that the new arrangements might present an opportunity for the detention center to secure financing for expanded mental health treatment within the facility as well as enhanced treatment for youth in the community.

Soon, they began to contemplate a much more ambitious, even audacious, plan: to open their own free-standing mental health clinic for court-involved youth who were not locked inside the detention center.

Dr. Linda Smith, a clinician who observed the clinic for several years while working in the county’s juvenile probation office before being hired as the clinic’s director in 2010, describes the logic behind the clinic this way: “If a youth has significant mental health issues, that would probably lead to high recidivism. If you could offer mental health services, and the youth was motivated to attend, the youth would receive the services and that would lead to lower recidivism.”

Organizing and Building a Mental Health Clinic

Planning and preparation for the clinic proceeded in three stages.

Ensuring Medicaid eligibility for detained youth. Even before they conceived the idea for a free-standing mental health clinic, Swisstack and Miera began working with the state to secure continuing Medicaid eligibility for detained youth — a critical ingredient both for financing enhanced services for youth inside the detention center and for improving the prospects that youth would continue receiving care after release. Until that time, detained youth in New Mexico — as in many or most jurisdictions nationwide — were routinely denied Medicaid coverage based on a federal law that prohibits coverage for individuals who are “inmates of public institutions.” However, the law specifically states that this coverage prohibition does not apply to any individual “in a public institution for a *temporary period pending other arrangements appropriate to his needs* [emphasis added].”

Swisstack and Miera met with state officials to seek a legal opinion on whether Medicaid billing was permissible for mental health services provided within the detention center. After researching the issues, state Medicaid officials, with concurrence from the federal regional office, determined that a youth would not be counted as an inmate of a public institution — and would therefore retain Medicaid eligibility — until adjudication or 60 days from placement in the detention facility, whichever occurred first. By clearly defining detention as a temporary living arrangement, this ruling assured continued coverage of youth during (and after) their stays in detention and eliminated any legal obstacles to billing Medicaid for therapeutic and assessment services provided to youth inside the detention center.¹⁴

Miera and Swisstack also convinced state officials to allow “*presumptive eligibility*” for all youth entering the detention center and mental health clinic. Under this rule, the detention facility and clinic can initiate the Medicaid eligibility application for youth at intake, with all youth presumed to be eligible for Medicaid. The application is then sent to the Department of Human Services for final eligibility determination. Because Medicaid eligibility is based on the date an application is submitted, any services provided to the youth are reimbursable, so long as the youth is eventually determined Medicaid eligible. This simple regulatory clarification opened Medicaid-allowable services to the detention and clinic populations, and it facilitated expeditious movement of youth out of the detention center and into outpatient care either in the clinic or with other community providers.

Becoming a licensed, certified and credentialed Medicaid provider. Bernalillo’s next step was to get the detention center licensed as a certified health care provider under the state’s Medicaid program. However, New Mexico had no category for providing mental health services to children in this type of setting. So, with assistance from the Department of Human Services’ Medicaid staff, the Department of Health licensing staff, and the New Mexico Children, Youth and Families Department licensing and program staff, a new certification category was developed specifically to accommodate this program.

Creating the outpatient clinic. At the same time county leaders were certifying the detention center as a licensed and Medicaid-eligible mental health provider, they also gained certification for a new outpatient adolescent mental health clinic adjacent to the detention center to serve youth outside the detention facility, including those participating in detention alternative programs or on probation supervision in the community. To earn this certification, detention center leaders had to: develop policies, procedures and manuals, and treatment plan forms; devise a training program and provide staff training; develop a pharmacy program with appropriate security for psychotropic drugs; and erect and furnish the clinic facility. Also with grant funding from the Annie E. Casey Foundation, Bernalillo staff developed an electronic Medicaid billing capability and secured needed equipment, such as computers and copiers.

Another key step toward establishing the mental health clinic was to secure both short-term and long-term funding from the three managed care organizations overseeing mental health care in New Mexico's Medicaid program. In the past, the managed care organizations had not been asked to pay for the care of detained youth, due to the perception that these youth were institutionalized (and therefore ineligible for Medicaid support). Once they had secured the new state ruling stating explicitly that detained youth remained eligible, Bernalillo leaders solicited the managed care companies for support. Specifically, Bernalillo convinced all three agencies to certify the detention center and the new outpatient clinic as mental health providers, making both eligible for Medicaid reimbursement for services provided. In addition, Swisstack and Miera secured up-front funding from all three agencies (totaling \$74,000) to support operations of Bernalillo's new clinic in the first year. One agency also provided a part-time staff person on loan to help with the billing and payment process.¹⁵

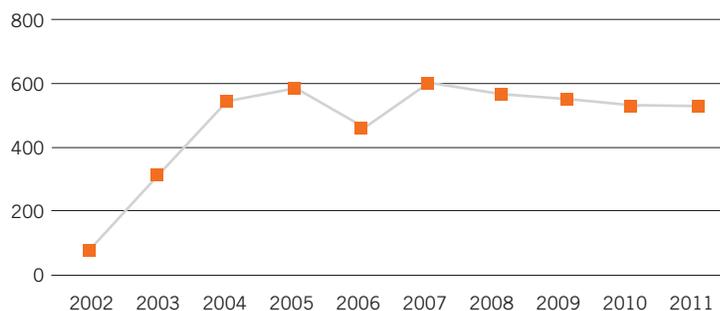
Nuts and Bolts of the Bernalillo Clinic

In January 2001, Swisstack hosted a community meeting to describe his ideas for the outpatient clinic and to solicit community support. Detention center staff then worked throughout 2001 to bring their plans for the clinic to fruition. The Bernalillo outpatient mental health clinic opened its doors in January 2002. Then, as now, the clinic was housed in temporary classroom buildings donated by Kirtland Air Force and installed on land adjacent to the detention center.

Staffing. Like the mental health program inside the detention center itself, the mental health clinic used a mixed provider staffing model, with some of the therapeutic staff employed by the detention center and some working as privately contracted Medicaid providers. For instance, Swisstack contracted with Dr. George Davis, the University of New Mexico child and adolescent forensic psychiatrist already involved with the detention program, to serve as medical director and provide psychiatric care and medication management. Meanwhile, the clinic used county employees (many of them retrained former detention center workers) to work as case managers for youth served by the mental health clinic. The clinic also employed a receptionist to handle appointments and scheduling and billing staff to process all reimbursement requests for private counselors, therapists and psychiatrists working in the clinic. Notably, until July 2010 the clinic did not have a full-time director — which Swisstack now considers a mistake, given the difficulties involved in both ensuring high-quality treatment and managing a costly and financially complex operation.

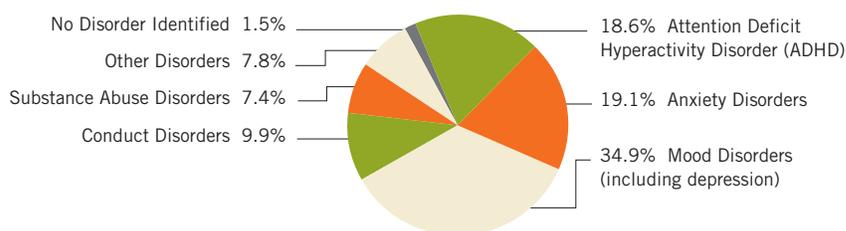
As of early 2012, the clinic's staff included a full-time clinical director (who supervises all aspects of the clinic operation and conducts many assessments of individual youth); two part-time and independent (i.e., nonstaff) licensed counselors; a psychiatrist from the University of New Mexico who works at the clinic 10 hours per week; two clinical case workers; a receptionist; two billing specialists; and an office supervisor.

NUMBER OF YOUTH PARTICIPANTS ANNUALLY



Clientele. During its first six months of operation (the second half of the 2001–02 fiscal year), the new mental health clinic served a total of 77 children and youth. That figure rose to 313 young people in FY 2003 and 545 in FY 2004. Since then, participation has fluctuated between a high of 601 (in FY 2007) and a low of 462 (in FY 2006). In order to qualify as a Medicaid-eligible clinic, the mental health clinic is required to serve children of all ages, referred from anywhere in the county. However, the vast majority of clinic clients have been court-involved youth, most of them referred through the probation department (which is housed in the same juvenile justice complex as the detention center and clinic). In FY 2011, about 80 percent of clinic clients were boys, and virtually all were 12 years old or older.

PRINCIPAL DIAGNOSIS OF YOUTH SEEN IN 2011



In order to receive services in the clinic (or qualify to receive services reimbursed via Medicaid), all youth must be assessed and diagnosed with one or more mental health conditions. (In fact, conducting assessments is a major component of the clinic’s work.) Of all youth seen in the clinic in 2011, 19 percent suffered with Attention Deficit Hyperactivity Disorder (ADHD) as their most serious condition, 19 percent with adjustment or anxiety disorders, 10 percent with conduct disorders, 35 percent with mood disorders (such as depression), and 7 percent with substance abuse disorders. Most youth suffered with multiple conditions.¹⁶

Referral process. As noted earlier, most youth seen in the clinic are referred by probation officers. Any time a young person is referred to juvenile court in Bernalillo County, he or she is immediately assigned to a probation officer. The first responsibility of the probation officer is to conduct a triage process to preliminarily identify needs and challenges. When the probation officer learns or suspects that a young person has mental health issues, the next step is typically to approach the Medicaid managed care agency for approval to conduct a psychiatric assessment (unless a recent and complete assessment is already available), and then to refer the youth to a community provider for this assessment. The detention center’s outpatient clinic, however, is just one of many mental health providers in the Bernalillo area to which probation officers make referrals. In fact, several organizations provide a far larger volume of mental health services for Bernalillo adolescents.¹⁷

In selecting a provider to conduct an assessment (or provide treatment), probation officers consider a range of factors, including the young person's needs, their home neighborhood, the range of programs and services offered by the respective providers, and the timeframe within which the assessment can be scheduled and completed. In addition to these client-related factors, explains Bernalillo Juvenile Probation Chief Jeanne Masterson, the choice of referrals is often tied to probation officers' experience with the providers — and particularly to the providers' competence in completing thorough, high-quality assessments with treatment recommendations justified clearly enough to gain easy approval from the Medicaid managed care agency that reviews treatment expense claims. According to both Masterson and clinic Director Dr. Linda Smith, the quality of assessments provided by clinic staff has been uneven over the years, though quality has improved since Smith took over the clinic in mid-2010.

The final factor driving many of the referrals to the detention center's outpatient clinic — and, indeed, one of Swisstack's prime motivations for opening the clinic — is to serve youth assigned to JDAI-inspired detention alternative programs. As noted previously, a key element in Bernalillo's detention reform efforts has been the creation and substantial expansion of its detention alternatives, especially the youth reporting center (along with a gender-specific girls reporting center, created in 2008), and the community custody program, where Swisstack's staff monitor youth on home detention through a combination of home visits, phone calls and electronic monitoring devices.

Treatment services. Once client youth have been assessed, the Bernalillo outpatient clinic provides a limited array of mostly conventional mental health services, including prescriptions and medications management, individual counseling, group therapy, substance abuse therapy (provided in both individual and group formats), and Comprehensive Community Support Services (CCSS), a form of case management aimed at empowering youth and their families to solve problems in addition to providing practical support.¹⁸

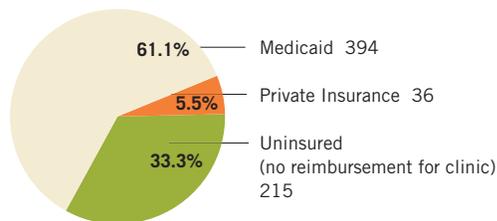
Many youth participate in multiple forms of therapy and treatment. In FY 2010–11, for instance, 402 of 529 clients received some form of treatment (119 received only an assessment, and service records were unavailable for the remaining eight youth.) Of the 402 youth participating in treatment services, 115 received only medication management, 50 participated in individual and/or group counseling only, and nine participated only in the CCSS case management program. Of the remaining youth, 189 received an assessment plus one more form of treatment, and 49 received two or more forms of treatment but not an assessment. Among youth who received multiple forms of treatment, the most common combinations were therapy plus CCSS case management, and therapy plus medications management.¹⁹

Logistical support. In addition to these treatment services, the clinic has a back office operation dedicated to scheduling appointments and boosting attendance through regular phone calls and other reminders. The clinic employs two specialists to handle Medicaid billing for all services provided at the clinic, including services provided by independent therapists and private providers who offer services to clinic patients.

Budget (and reimbursements). Though Bernalillo’s success in generating Medicaid reimbursement for mental health treatment for youth inside the detention center and in the outpatient clinic was groundbreaking, Swisstack insists that Bernalillo did not establish its mental health programs to make money, and that money has never been the driving factor in the clinic’s operations. A look at the clinic’s budget supports this claim.

In FY 2010–11, the total budget for the clinic was \$613,000. Of this amount, only about one-third (\$197,161) was recouped through reimbursements from Medicaid, and very little was recovered through private insurance (\$3,276).²⁰ The bulk of the clinic’s costs (more than \$400,000) were paid from the detention center’s core budget, which is funded primarily through county tax receipts. The large gap between costs and reimbursements results from two factors. First, many of the services provided by the clinic are uncompensated: one-third of the youth seen at the clinic are uninsured, whereas 61 percent are Medicaid eligible and 6 percent have private insurance.²¹ Second, in order to attract the best clinicians possible, Swisstack decided early on to make working at the clinic as lucrative as possible for private clinicians and therapists. As a result, the detention center pays for all of the costs associated with scheduling and billing, as well as all of the clinic’s rent and operating expenses. Private clinicians are not charged any overhead, and are allowed to keep 100 percent of the Medicaid reimbursements collected for their work providing assessments and treatments.

INSURANCE STATUS OF YOUTH SEEN AT THE CLINIC IN 2011
645 youth served



This substantial investment is testimony to Swisstack’s belief in and commitment to the mental health clinic — and to the willingness of Bernalillo’s county commission to support detention reform by allowing Swisstack to reallocate funds saved by reducing detention populations (and lowering custodial costs) into programs designed to keep youth out of detention. “We didn’t go into this to generate money,” Swisstack says. “Our intent all along has been to get prompt and professional services for youth and to get the child back into the community.” In 2000 and again in 2002, Swisstack was able to close wings within the detention center due to declining daily populations — resulting in substantial savings, says Swisstack. “I convinced my local legislators to let me reprogram the money if I reduced the population, so I just needed [the clinic] to remain cost-neutral.”

Assessing the Clinic's Impact

Though the clinic has been operating for a decade now, it remains difficult to quantify its impact. The clinic was not designed as a controlled experiment, and Bernalillo County's juvenile detention agency had very limited data collection and analysis capacity in the early days of the clinic's operations. Measuring the clinic's impact is further complicated by the fact that Bernalillo established the mental health clinic at the same time it was introducing a number of other major reforms and changes, including new screening criteria for detention, a wholesale expansion of detention alternative programs, and new procedures to reduce lengths of stay in detention as well as admissions related to bench warrants and rule violations. Yet, even without clear quantitative proof of the clinic's impact, there is unanimous consensus among key leaders involved in Bernalillo's juvenile court and detention programs that the clinic has been beneficial in helping the county reduce its population in secure detention, keep the population down over time and improve youth outcomes.

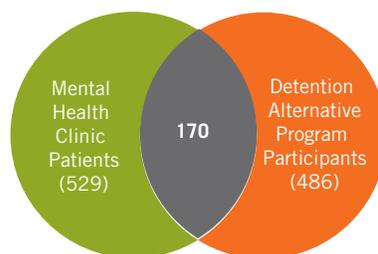
By reviewing the available data and interviews with key leaders, several mechanisms can be identified through which the clinic appears to be making a measurable difference.

Allowing more youth to participate in detention alternative programs, rather than secure detention. Whenever a young person is referred to juvenile court in Bernalillo County for a new offense, their case is discussed in a meeting among staff from the county's juvenile probation agency, public defender office, detention center and detention alternative programs. Together, meeting participants try to agree on a plan for youth regarding detention: should he or she be detained, or placed in a detention alternative program. According to Leslie Jiron, program manager for Bernalillo's two main detention alternative programs — community custody and youth report centers — whenever a youth is recommended for possible participation, “we make a decision on whether we're going to let a child in to the programs.... Kids that I would probably deny because of a serious mental health or substance abuse problem, I feel more comfortable taking them in if they're being seen at the clinic. Especially if they've been assigned a case worker, I feel much more confident to take them.” In other words, without access to the mental health clinic, many youth who currently participate in detention alternatives would instead be locked in secure detention.

Data from FY 2011 show the substantial overlap between the populations served by the mental health clinic and detention alternative programs. As shown in the chart on p. 18, 170 youth both participated in a detention alternative program during FY 2011 and visited the mental health clinic for assessments and/or treatment services. In other words, 35 percent of youth (170 of 486) participating in a detention alternative program in FY 2011 also received services at the mental health clinic, while 32 percent of youth visiting the clinic (170 of 529) also participated in a detention alternative program.²²

Boosting success rates of youth in detention alternative programs. One of the most encouraging trends in Bernalillo’s detention reform efforts in recent years has been the steadily improving success rates of youth diverted from secure detention into the community custody and youth reporting center programs. According to a new data report released by Bernalillo County in December 2011, the success rate of youth participating in these detention alternative programs has risen from 75 percent in 2005 to 91 percent in fiscal years 2009–10 and 2010–11, where success is defined as attending court as scheduled and not getting arrested for a new offense.²³ While the mental health clinic is not the primary or only factor in youths’ success in these detention alternative programs, Jiron describes the clinic as a valuable partner. “If the child is starting to drop off because of a dirty drug test maybe or a family problem,” she says, “having those wraparound services really helps.” Likewise, Jiron adds, “if kids need medication management, it’s reassuring to me that we’re able to monitor them right here on site, not just refer them to some provider in the community.” Juvenile Probation Chief Jeanne Masterson says, the clinic’s location next door to the detention alternative programs is a major benefit. “Other agencies you call, make an appointment and who knows when you’ll be seen,” Masterson says. “To have that resource right here on site is huge.”

**BERNALILLO COUNTY YOUTH DETENTION CENTER
Overlap Between Detention Alternative Programs
and Mental Health Clinic Population**



Participants in FY 2011

Reducing lengths of stay by speeding release from detention. Another benefit the clinic offers is helping the county’s case expeditor develop solid service plans for youth who remain in detention for extended periods. In many cases involving youth with serious mental health needs, judges may be unwilling to release youth from detention absent a solid connection to a mental health treatment provider. However, Bernalillo has long suffered with a shortage of adolescent mental health treatment providers — and particularly a shortage of providers who are eager to be and expert in working with deeply troubled youth. The clinic often fills this void — connecting detained youth to treatment and thereby providing judges

the assurance they need to release young people from detention on community supervision. “It affects my decision making in that it’s another option,” says Judge John J. Romero Jr. “Especially when we can offer the case management in conjunction with the community custody program, it offers me another responsible caregiver, and that can influence my decision.”

Juvenile Probation Chief Jeanne Masterson also sees a big impact: “Prior to the clinic, if we knew a kid needed services, then we had to hold the child [in detention]. Now it’s easier to link the child to services, walk them down the parking lot and introduce them to a clinical person.” In addition, says Masterson, “lots of probation officers would recommend holding a young person until an assessment is conducted, because they didn’t want to read in the papers that the kid they sent home did something terrible. Now, we can get that kid assessed right away.”

Boosting success of youth on probation. The final mechanism through which the Bernalillo mental health clinic appears to be enhancing detention reform is by providing more or better mental health care to youth under probation supervision than these youth could receive absent the clinic. While Bernalillo does not have data to prove that the clinic’s services are responsible for improving outcomes for its probation clients, an analysis conducted by Bernalillo data staff in February 2012 suggests that the services are indeed paying dividends: Of 100 youth released from secure detention in 2010–11 with mental health referrals who received counseling or treatment from the clinic, only 10 were rebooked into detention while in treatment.²⁴ Meanwhile, Bernalillo’s key juvenile justice leaders all say that the clinic has an important beneficial impact. Talking about youth with mental health issues who are released from detention following arrest, Probation Chief Jeanne Masterson says, “they aren’t just going home, they’re going home with some services bundled up with that.” Adds Swisstack: “I have no doubt that if the clinic went away, my population inside the detention center would go up. . . . The success rate goes up because we’re working hand in glove.”

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“PRIOR TO THE CLINIC, if we knew a kid needed services, then we had to hold the child [in detention]. Now it’s easier to link the child to services, walk them down the parking lot and introduce them to a clinical person.”

— Juvenile Probation Chief Jeanne Masterson

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Key Advantages of the Onsite Clinic

In describing why they believe the clinic is causing these favorable outcomes, Swisstack and other Bernalillo leaders point to several discreet advantages the clinic holds over existing treatment providers in the Bernalillo community.

- **Convenience.** First is that the clinic is convenient and easy to access for court-involved families, especially those where young people are participating in the youth reporting center programs. “The fact that it’s here rather than elsewhere in the community is really helpful to the families who need to be here on a regular basis,” says Judge Romero. The clinic’s psychiatric services are particularly valuable, adds Masterson, because “kids can now leave the detention home with medications in hand and know where to go for a refill prescription when they need it.”
- **Focus on juvenile justice population.** Unlike many therapists and social workers in the Bernalillo community, the detention center’s outpatient clinic is specifically designed to focus on and work with a juvenile justice population, and its staff has expertise and motivation to serve these behaviorally troubled youth, even when they are difficult. As clinic Director Dr. Linda Smith explains, “Even though there are a lot of agencies providing services in the community, they’re often not real fond of our population. Getting [these youth] motivated can be a problem, a lot of them are into drugs, some have pretty alarming behaviors. They’re not an easy population.”
- **Capacity to promote attendance.** The clinic is also better equipped to address the challenge of ensuring youths’ attendance at scheduled treatment sessions — a matter of both clinical and fiscal significance. “Getting our youth to attend treatment regularly is difficult,” Smith says. Over the years, the clinic’s scheduling and reception staff have developed increasingly elaborate procedures to call and remind youth about their appointments and encourage attendance. Thanks to these extensive outreach efforts, 80 percent of youth scheduled for assessments or treatment sessions at the clinic actually attended their scheduled appointments in 2010–11.²⁵ “A lot of other providers in the community have other clients...and won’t go to that trouble for this population,” Smith says. “The clinic fills that void.”
- **Smooth transitions/continuity of care.** The final key advantage offered by the Bernalillo clinic over other mental health providers in the community is the capacity to enhance continuity of care for youth as they exit secure detention and either enter a detention alternative program, begin probation supervision or return to family life. Unlike other jurisdictions, and unlike Bernalillo County in the days prior to the clinic, youth with mental health challenges who are released from the detention center today typically leave with a mental health care provider, a prescription for appropriate medications (if needed) and a treatment plan.

Issues and Challenges for Bernalillo County, and Lessons Learned

For all of the reasons detailed above, the leaders of Bernalillo County's juvenile court system and detention programs all believe that the mental health clinic has been an important cog in the county's striking success in detention reform.

However, they also acknowledge that the clinic has faced a variety of difficulties and challenges since opening its doors in 2002.

- **Attracting, retaining and supervising top-flight clinicians.** While pleased generally with the results of the clinic, Bernalillo leaders concede that finding high-quality staff has been a challenge. In fact, Probation Chief Jeanne Masterson reports that the uneven quality of mental health assessments provided by clinic staff has dissuaded some probation officers from referring cases to the clinic. "The probation officers need to know that they're going to get high-quality assessments, typewritten, with diagnoses based on current behaviors that can pass muster with [the managed care agency]," Masterson says, "and at times my staff just wasn't getting what they needed." The impact of these problems is apparent in the clinic's lagging utilization from 2007 to 2010, when both the number of patients and insurance reimbursements (from Medicaid and other payments) saw significant declines. Masterson says the situation has improved since the clinic hired a full-time clinical director in 2010.
- **Providing proper training for case managers.** Particularly early on, the clinic also had difficulties with the staff providing case management and support services for youth. Initially, the clinic's case management services were provided mainly by staff reassigned from the detention center and provided with limited training. Poor results led Swisstack to develop a more thorough training regimen for these workers so they could work more effectively with youth — and their families — in the community setting.
- **Negotiating with Medicaid managed care organizations.** Initially, Swisstack and Miera negotiated with three Medicaid managed care organizations — Presbyterian Health Plan, Lovelace Health Plan and Cimmaron Health Plan — to get the clinic certified as a provider and then to develop financial agreements and protocols for the clinic's mental health services (and reimbursements). However, in 2005 the state of New Mexico transferred responsibility for all Medicaid-funded mental health services to a statewide purchasing cooperative, ValueOptions, which required Swisstack and his team to repeat the whole process, consuming dozens of staff hours. Then in 2009, the state transferred the mental health purchasing responsibility to yet another agency, OptumHealth, requiring Swisstack's team to renegotiate its arrangements one more time. Worse yet, OptumHealth's contract with the state is set to expire in June 2013, which may require the clinic to go through the process yet again.

- **Danger of overdiagnosing youth.** Another concern, endemic not just to the Bernalillo clinic but to adolescent mental health providers nationwide, is the danger that providers may be too eager to diagnose youth with mental health disorders. Under Medicaid rules, no treatment service will be reimbursed unless it is based upon a properly documented diagnosis, and Bernalillo’s clinic staff devotes a lot of its energies to conducting assessments and documenting mental health conditions. This set-up creates a danger of overdiagnosing youth. In addition, it contributes to a troubling national trend in which the juvenile justice system increasingly functions as a primary mental health provider for troubled youth. As Thomas Grisso, a nationally recognized expert on mental health and juvenile justice, has written, “If the juvenile justice system continues to be the community’s link to mental health services that otherwise are very hard to obtain, the risk will increase that some youths will be processed on delinquency charges merely to get services, at the cost of a delinquency record that will have later negative consequences for them. The long-range solution, of course, is to improve community mental health services for children.”²⁶

Questions and Implications for Other Jurisdictions

Despite these issues and challenges, the outpatient mental health clinic is clearly paying dividends for Bernalillo County — addressing a critical unmet need for youth with mental health difficulties, helping to hold down the population of youth in secure detention and making a significant contribution to the success of detention alternative programs.

However, replicating Bernalillo’s model and creating a free-standing mental health clinic for court-involved youth will not be a viable option for most jurisdictions throughout the country. All but the largest and most sophisticated jurisdictions will likely find the obstacles insurmountable.

- **Heavy start-up costs and logistical/bureaucratic challenges.** The most difficult hurdles are: (1) to work with state officials and any private managed care organizations involved in the state’s Medicaid program to clarify rules that ensure Medicaid eligibility for youth in temporary detention; and (2) to develop the detailed plans required to create a clinic and get it certified as a qualified provider.
- **Sizable ongoing gap between Medicaid reimbursements and total costs.** While reimbursements from Medicaid and other insurance will provide some income to support a clinic program, the operating costs will be far greater. Over time, the financial benefits of the clinic should outweigh the programmatic costs. By boosting the success of detention alternatives and reducing lengths of stay for detained youth with mental health issues, the clinic can lower detention populations and reduce custodial costs in the long term. However, Bernalillo’s experience shows that a mental health clinic will require ongoing operating support well beyond the income generated through Medicaid and other insurance.

Creating a free-standing clinic like Bernalillo’s will be more relevant in larger jurisdictions with administrative capacity to handle the sophisticated and time-consuming challenges involved in planning a clinic, getting it certified and handling ongoing challenges associated with billing, scheduling and clinic operations. Following Bernalillo’s example may be an attractive option in larger jurisdictions where mental health treatment services for court-involved youth are not strong, and where continuity of care proves persistently elusive as youth exit secure detention or participate in detention alternatives.

However, even in these circumstances, local detention leaders should hesitate before creating a mental health clinic. Not only should they be wary of the costs and complexities involved, but they should also recognize that operating a mental health facility spans far beyond the core mission of a detention center. These services are more suitably provided by a mental health department, a clinic or social service agency whose core mission and competency involve adolescent mental health treatment, or a collaboration involving multiple providers. Only if a fundamental breakdown occurs — when local providers prove consistently unwilling or unable to provide competent, timely and culturally relevant care — should the detention agency consider entering the mental health provider field.

Conclusion

Given the difficult challenges involved in licensing and start-up, the administrative burden and the ongoing financial costs, creating a free-standing mental health clinic is clearly not the best option for every jurisdiction involved in detention reform. On the other hand, Bernalillo County's successful experience shows that this can be a viable model, with significant benefits.

For jurisdictions that are not able or inclined to establish a free-standing clinic, Bernalillo County's experience offers three valuable lessons.

First is the critical importance of mental health care for youth in the detention process, and especially the importance of ensuring continuity of care for youth as they move through the court process. More specifically, Bernalillo's experience clearly demonstrates the important role mental health treatment can play in detention reform, helping to address the underlying needs of youth and to heighten their success in detention alternative programs.

Second is the importance of ensuring continuing Medicaid coverage for youth as they enter the juvenile court system. As Bernalillo County did prior to its entry to JDAI, many jurisdictions routinely terminate Medicaid coverage for youth as they enter a secure detention facility, despite the federal rules saying that youth in temporary detention should remain eligible. Even if your jurisdiction does not provide Medicaid-reimbursable services for youth held in detention or those participating in detention alternative programs, terminating Medicaid coverage will create an extra barrier to mental health treatment after release — and therefore increase the likelihood that the young person will fail and return to detention on a new charge.

Third, even if they do nothing to enhance mental health care provided to youth in secure detention — or to youth being supervised on home detention or in detention alternative programs — all JDAI sites should review their procedures regarding Medicaid coverage and take whatever steps are required to ensure that youth retain coverage while detained and can receive the mental health care they need upon release.

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ALL JDAI SITES should take whatever steps are required to ensure that youth retain Medicaid coverage while detained and can receive the mental health care they need upon release.

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ENDNOTES

1. Shufelt, J.L., & Coccozza, J.J. (2006). *Youth with Mental Health Disorders in the Juvenile Justice System: Results from the Multi-State Prevalence Study, Research and Program Brief*. Delmar, NY: National Center for Mental Health and Juvenile Justice. Retrieved from www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf
2. Gies, R., Canary, P.J., & Lovins, B. (2011). *Ohio's Institutional Juvenile Justice Reform Efforts: An Update for Stakeholders* (powerpoint presentation April 20, 2011). Covington, KY: Children's Law Center. Retrieved from <http://clcky.squarespace.com/webcasts/?currentPage=2>
3. Regarding Wraparound Milwaukee, see Kamradt, B. (2000). "Wraparound Milwaukee: Aiding Youth With Mental Health Needs." *Juvenile Justice*, 7(1). Retrieved from www.ncjrs.gov/pdffiles1/ojdp/178256.pdf; and Mendel, R.A. (2001). *Less Cost, More Safety: Guiding Lights for Reform in Juvenile Justice*. Washington, DC: American Youth Policy Forum. Retrieved from www.aypf.org/publications/lesscost/pages/full.pdf; and for the Washington State wraparound model, see Pullman, M.D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). "Juvenile Offenders With Mental Health Needs: Reducing Recidivism Using Wraparound." *Crime & Delinquency*, 52(3).
4. Cuellar, A.E., Markowitz, S., & Libby, A.M. (2004). "Mental Health and Substance Abuse Treatment and Juvenile Crime." *Journal of Mental Health Policy and Economics*, 7.
5. Henggeler, S., & Schoenwald, S.J. (2011). "Evidence-Based Interventions for Juvenile Offenders and Juvenile Justice Policies That Support Them." *Social Policy Report*, 25(1). Retrieved from www.mtfc.com/2011_EB_Interventions_for_Juv_Offenders.pdf
6. Author's calculations using data from the Survey of Youth in Residential Placement online database. Retrieved from <https://www.dataexplorer.com/Project/ProjUser/AdhocTableType.aspx?reset=true&ScreenID=40>
7. Ibid.
8. U.S. Government Accountability Office. (2003). *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*. Retrieved from www.gao.gov/new.items/d03397.pdf
9. Grisso, T. (2004). *Double Jeopardy: Adolescent Offenders With Mental Health Disorders*. Chicago: University of Chicago Press.
10. U.S. House of Representatives Committee on Government Reform — Minority Staff Special Investigation Division. (2004). *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States*. Retrieved from <http://www.hsgac.senate.gov/issues/health-and-public-safety>
11. Nellis, A., & Hooks Wayman, (2009). "Back on Track: Supporting Youth Reentry from Out-of-Home Placement to the Community." *Youth Reentry Task Force of the National Juvenile Justice and Delinquency Prevention Coalition*, 25. Retrieved from http://njjn.org/uploads/digital-library/resource_1397.pdf
12. Cuellar, A.E., Kelleher, K.J., Rolls, J.A., & Pajer, K. (2005). "Medicaid Insurance Policies for Youths Involved in the Criminal Justice System." *American Journal of Public Health*, 95(10). Retrieved from www.nationwidechildrens.org/document/get/45375
13. At this time, neither Bernalillo County's detention center nor its juvenile court had sophisticated data systems to track results or analyze the impact of improved mental health counseling. So the precise impact of the enhanced mental health care inside the detention facility was never measured. Nonetheless, both Swisstack and Miera both recall that the enhanced services made a significant (though time-limited) difference for youth inside the detention center.
14. Specifically, the New Mexico Department of Human Services ruled: "An individual is not considered to be living in an institution if he is placed in a detention center for a temporary period pending other arrangements appropriate to his needs. For purposes of Medicaid eligibility, an individual who is placed in a detention

center will be considered to be temporarily absent from the home, provided the stay in the detention center does not exceed 60 days. The stay in a detention center ceases to be considered a temporary absence once the stay exceeds 60 days, or until the dispositional hearing occurs, which ever first occurs.” (8.200.410.15 NMAC)

15. Lepler, S., Skowyra, K.R., & Cocozza, J.J. (2007). *Blueprint for Change: Funding Mental Health Services for Youth in Contact With the Juvenile Justice System*. Delmar, NY: National Center for Mental Health and Juvenile Justice. Retrieved from www.ncmhjj.com/pdfs/publications/BlueprintFunding.pdf
16. Data provided by Dr. Nicol Moreland, Bernalillo County Youth Services Center, January 2012.
17. Major providers of adolescent mental health services in the Bernalillo County/Albuquerque area include: Hogares, Youth Development Incorporated, University of New Mexico, All Faiths Receiving Home, New Mexico Solutions and Southwest Family Guidance.
18. In addition, clinic youth participate occasionally in alternative therapies, such as a ropes course, developed by the detention center counseling staff for youth in secure detention.
19. Data provided via email by Mr. Craig Sparks, Bernalillo County Youth Services Center, April 2012.
20. Data provided by Ms. Dominique Velasquez, Bernalillo County Youth Services Center, December 2011.
21. Data provided via email by Dr. Nicol Moreland, Bernalillo County Youth Services Center, February 2012.
22. Data provided via email by Mr. Craig Sparks, Bernalillo County Youth Services Center, March 2012.
23. Swisstack, T.E., Matteucci, L., Mitchell, D.E., & Leyba, C. (2011). *Smaller, Smarter, and More Strategic: Juvenile Justice Reform in Bernalillo County*. Albuquerque, NM: Bernalillo County Youth Services Center.
24. Data provided via email by Dr. Nicol Moreland, Bernalillo County Youth Services Center, February 2012.
25. Attendance data taken from Bernalillo County Children’s Community Mental Health Clinic Annual Report, July 1, 2010 – June 30, 2011, provided via email by Dr. Linda Smith, Bernalillo County Youth Services Center, April 2012.
26. Grisso, T. (2007). “Progress and Perils in the Juvenile Justice and Mental Health Movement.” *Journal of the American Academy of Psychiatry and the Law*, 35(2). Retrieved from www.jaapl.org/content/35/2/158.long



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