

A SHORTAGE OF MENTAL HEALTH SERVICES DRIVES INAPPROPRIATE PLACEMENTS IN JUVENILE DETENTION

Recent reports paint a disturbing picture of youth with mental health difficulties being “warehoused” or “dumped” in juvenile justice detention centers because appropriate treatment is not available. Thousands of young people with mental health needs are held in detention for minor offenses that normally do not warrant detention, and others linger in detention facilities even though they have not been charged with any crime. In some cases, youth become entangled with the juvenile justice system because their parents believe that this is a route to accessing mental health services. Tragically, most of these young people do not receive the treatment that they need. Remedies for these problems are being explored, and often rely on collaboration and creative funding.

Optimally, most of the children with mental health needs who are currently in detention would instead receive community-based treatment, while some others would be placed in residential treatment facilities. However, appropriately intensive care is often not covered by private health insurance. Even under mental health parity legislation, which prohibits insurance companies from covering mental health problems differently than other health issues, loopholes limit days of care, treatment episodes, or diagnoses covered. For instance, serious emotional disorders, personality



disorders, and child substance abuse are typically not covered at all, thus precluding access to intensive community-based outpatient treatment and residential treatment (National Mental Health Association, 2005).

When insurance does not cover intensive treatment, families are often unable to pay the high costs of private care (up to \$250,000 for residential mental health programs), and some families turn to law enforcement agencies for help. Parents who cannot access community-based supports or services may become overwhelmed by their children’s troubling or aggressive behaviors. With nowhere else to turn, they may call police to the home

to help manage an argument, outburst, or crisis. Police may encourage families to place charges so that children can get access to mental health services within the juvenile justice system. Sometimes, police and other agency officials do not have accurate knowledge about services available through the juvenile justice system, and they can lead families to believe that their child will receive services that are actually unavailable. In total, more than 9,000 children per year are placed in juvenile justice systems just so that they can receive mental health care (US GAO, 2003).

Juvenile justice detention facilities are also increasingly holding youth with mental health difficulties who have committed only minor offenses (US House, 2004). “Zero tolerance” policies in schools are an

important contributor to this phenomenon. Such policies are extremely rigid, and can require law enforcement involvement even for minor incidents. Documented incidents include a child disciplined under zero-tolerance policy for accidentally hitting a teacher during an epileptic seizure, and a five-year-old handcuffed by police for having a temper tantrum (NAACP, 2006). In Florida alone, a one-year review found that 76% of the 30,000 law enforcement referrals were for incidents such as trespassing and disorderly conduct, which are often labels given to school-yard fights (NAACP, 2006). For children with emotional and be-

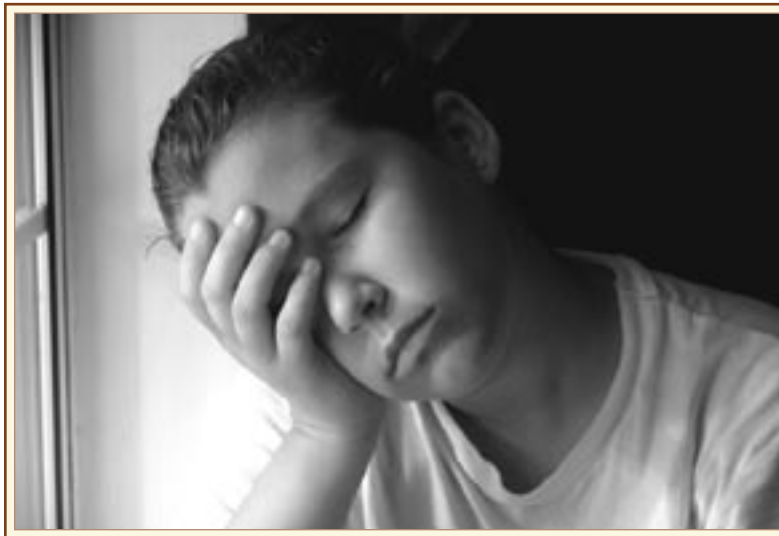
havioral disorders, zero tolerance policies require the juvenile justice system to become involved in incidents that would previously have been handled by school administrators.

When services are scarce, children may be placed in detention facilities even when they have committed no crime at all. Waiting lists for care are often long, due in part to the low reimbursement rates that Medicaid offers to mental health professionals and facilities. State officials report long waiting times for youth mental health residential treatment beds, as well as a lack of age-appropriate placements to serve children with mental health needs (US GAO, 2003). Some children who have committed no crime at all are placed in detention facilities because they are depressed or suicidal, and there are no beds available in mental health facilities. Two-thirds of juvenile detention facilities report holding children, sometimes as young as seven, who are awaiting

mental health placements. Overall, about 7% of youth in detention facilities are awaiting mental health placement (US House, 2004).

Unfortunately, once children with mental health needs enter a detention facility, they are unlikely to receive necessary care. In 2003, a study of the California Juvenile Justice system conducted by the National Council on Crime and Delinquency (Hartney, McKinney, Eidlitz & Craine, 2003) found that 67% of California youth detention facilities reported not having appropriate means to meet the needs of children with mental health problems, and over half of the detention centers reported that no individual therapy is available to youth in detention. The juvenile justice ad-

ministrators who participated in this research reported that children with mental health problems receive inappropriate placements, spend more time than necessary in detention, enter into placement further from home, face increased family problems due to inappropriate placement and services, receive poor follow-up after release from detention, and are poorly prepared for aging out of the system. Higher rates of recidivism and violent behavior while in custody are other problems associated with these children. Another disadvantage that many children experience is the discontinu-



ation of their Medicaid while they are in detention; often they must wait 1-3 months for its reinstatement upon their release (Hartney et al., 2003).

Federal law does not require, but “strongly suggests” that detention facilities provide mental health treatment. Juvenile justice facilities are generally not eligible for Medicare or other state insurance programs because of federal eligibility criteria; thus, resources for mental health treatment come from general operating funds (Hartney et al., 2003). The expenses of mental health care are particularly burdensome for small detention centers. Some detention centers have creatively used grants to cover mental health costs. Other centers have collaborated with schools or

other agencies that can receive federal reimbursement to create intensive day treatment programs. Some county detention facilities have interpreted the policy that discontinues Medicare funding to youth in the juvenile justice system to mean that a youth’s Medicare coverage is not discontinued until formal sentencing, thereby extending the timeline of Medicare eligibility. In Massachusetts, the state Medicaid agency continues to cover children in detention, reimbursing the juvenile justice system for the portion of funds that the federal dollars will not cover in order to provide better mental health access (US GAO, 2003).

States have a variety of options for promoting appropriate community-based mental health care or appropriate residential settings for youth in lieu of placing them in detention centers. Some strategies to make community-based care more accessible focus on families who are too well off to receive Medicaid, but whose private insurance does not cover

intensive treatment. For instance, children who meet disability criteria can receive additional care in states that exercise the “Kate Beckett” rule (although only ten states are currently exercising this option). This rule allows states to use federal Medicaid funding to cover home-based treatment in lieu of institutional care, and does not require that families have limited income. States are also expanding their State Children’s Health Insurance Programs (SCHIP) to offer eligibility to those families whose earnings are too high to receive Medicaid. Benefits of SCHIP programs include early mental health screening and treatment. States can also exercise the Medicaid Home- and Community-Based Services waiver to pro-

vide services to targeted groups who would otherwise require placement in a hospital, nursing facility, or intermediate care home, as long as they substantiate that the services are provided at a cost-savings over institutionalized care that Medicaid would otherwise provide (US GAO, 2003).

health services in schools to provide enhanced screening and services. Other communities have implemented services such as mobile crisis-intervention programs, transitional service programs for youth leaving mental health residential care, therapeutic summer camps, respite care, and pro-

livery to youth in the California juvenile justice system: Summary of findings. [Electronic version.] *Views from the National Council on Crime and Delinquency*.



NAACP Legal Defense and Education Fund. (2006). *Arresting development: Addressing the school discipline crisis in Florida*. Retrieved May 8, 2006, from http://www.naacpldf.org/content/pdf/pipeline/Arresting_Development_Full_Report.pdf

National Mental Health Association. (2005). *It is time to pass comprehensive health insurance parity!* Retrieved May 5, 2006, from <http://www.nmha.org/state/parity/index.cfm>

U.S. Congress. (2004). House of Representatives, Committee on Government Reform. *Incarceration of youth who are waiting for community mental health services in the United States*. (Accession Number 020256/Kutak VF 1030 Incarce). Washington, DC: Author. Retrieved April, 2006, from http://www.house.gov/reform/min/pdfs_108_2/pdfs_inves/pdf_health_mental_health_youth_incarceration_july_2004_rep.pdf

When more community-based resources are available, parents are less likely to turn to public institutionalized care (US GAO, 2003). In 2004, Congress passed the Mentally Ill Offender and Treatment Crime Reduction Act, which offered \$50 million to states for pre-and-post-booking services. Some communities have tapped into these funds to create mental health court diversion programs. Other creative partnering and funding techniques have included establishing coalitions to blend their funds and offer services to children, comprehensive screening, and tapping into states' flexible funds to pay for nontraditional services. Some counties have brought together multiple services under one roof to provide easier access and collaboration, or have co-located mental

programs that target parent involvement in mental health planning.

It is clear that jailing children or turning them over to authorities is not an adequate remedy for the widespread lack of access to appropriate mental health care. Recent efforts have demonstrated that it is possible for state and federal governments, juvenile justice systems, mental health providers, and families to creatively work together to reduce inappropriate placements of young people in detention, and to promote more suitable mental health treatment.

US General Accounting Office. (2003). *Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services*. (Publication No. GAO-03-397). Retrieved April 12, 2006, from General Accounting Office Reports Online: <http://www.gao.gov/new.items/d03397.pdf>

Melanie Sage is a PhD student in the Social Work Program at Portland State University. She is a Research Assistant at Portland's Regional Research Institute for Human Services.

References

Hartney, C., McKinney, T., Eidlitz, L., & Craine, J. (September 2003). A survey of mental health care de-

Thank you! This issue was made possible by the assistance of the following people: Ariel Holman, Maria Everhart, Pauline Jivanjee, Mary Dallas Allen, and Donna Fleming. We couldn't have done it without you!