

**FOSTERING PARTNERSHIPS: THE JOCHS APPROACH TO
COMMUNITY-BASED HEALTH CARE FOR YOUNG OFFENDERS**

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For young people who are arrested and brought to juvenile detention centers, there is a tremendous opportunity to make a positive and significant impact on their lives by connecting them with community health care providers.

The Juvenile Offenders Community Health Services (JOCHS) project is a new initiative to foster partnerships between local juvenile justice systems and community health care providers. Its goal is to assist jurisdictions in creating a continuum of high-quality, community-based, physical and mental health services for youth entering and leaving detention. The JOCHS project envisions that juvenile offenders will receive age-appropriate and culturally competent care in detention centers from providers who will remain accessible to them when they reintegrate into their communities. The California Endowment, the Robert Wood Johnson Foundation, and the Community Clinics Initiative jointly support JOCHS.

I. Purpose

The information in this paper is meant to support county probation and health care agencies and their community partners as they assess and consider changes to their local juvenile justice health care system. This paper:

- Introduces the underlying principles of the JOCHS approach which is centered on connecting health care in detention back to the community;
- Synthesizes lessons learned from the new Alameda County Juvenile Justice Center and from the Community Oriented Health Care Services project that are relevant to the design of community-based health care systems for juvenile offenders around the state;
- Provides county juvenile detention centers and community health providers with information and guidance to re-shape their services to create continuity of care for youth as they move into, through, and out of the juvenile justice system;
- Describes some of the potential funding streams that may be available/appropriate to utilize for health services in juvenile justice systems; and,
- Identifies some of the issues involved in adapting and implementing this approach in a given juvenile justice system and community.

II. The JOCHS Project

The JOCHS project explores a promising approach for delivering integrated physical and mental health services to vulnerable youth that maximizes the use of existing institutions and funding streams. It changes the opportunities available to young offenders, a population that is predominantly comprised of low-income boys and young men of color. JOCHS' goal is to connect youth who are brought to detention centers with health care services provided by community health care centers. We encourage partners and policymakers to view detention as an opportunity to rethink health care delivery for all children and youth in their jurisdiction, and to provide care that is age-appropriate and culturally sensitive, and reflects local standards. By bringing community health care providers into juvenile detention centers, JOCHS seeks to establish stable medical homes for juveniles in their communities. JOCHS views detention as an opportunity to provide young offenders with access to the health care they need - not only when they are brought to detention - but also after they leave detention and return to their community.

The medical and behavioral health conditions of detained youth bear a direct relationship to public health concerns regarding substance abuse and mental, reproductive, and oral health conditions. These youth are often identified as "hard to reach; hard to treat," a definition based on the reality that many may not have accessed health care services since they were young children, may have no established baseline or history of care, and may not be enrolled in an insurance plan or in Medi-Cal. They tend to exist outside the parameters of the health safety net with little attention paid to their healthy development.

Many juvenile offenders are booked into detention centers with pre-existing - and often untreated - mental and physical health conditions that require both immediate and long-term treatment if they are to be effectively resolved. Research conducted over the past decade demonstrates that, increasingly, the justice system is the first place a youth in trouble is identified with these conditions.¹

¹ For more information on mental health and juvenile offenders, please see: Bussiere, Alice and Sue Burrell. *Improving Access to Medi-Cal for Youth in the Juvenile Justice System*, Youth Law Center, 2006. Accessed on the Internet in April 2009 at: www.ylc.org

Since youth entering detention also frequently do not have a regular doctor or other health care provider, when they leave detention they often stop receiving care. Lack of continued treatment increases the odds that they will get into trouble again, contributing to high recidivism rates for juvenile offenders. In California, statistics show that approximately 70% of youth released from state custody are arrested again within three years of release.²

The JOCHS concept helps young offenders establish a stable medical home in the community that they might not have otherwise, and provides connectivity to community-based services that can support their on-going health care, rehabilitation, and development.

Background

The JOCHS approach is based on the experience of two projects: the Alameda County Juvenile Justice Center (JJC), an early example of a community-linked approach to health care for youth offenders, and from Community Oriented Correctional Health Services (COCHS), the model of community integrated re-entry programs for adult offenders discussed and implemented in various sites across the country.

Following a comprehensive review of the Alameda County Juvenile Justice system in 2004³, the County initiated a planning process to rebuild its aging and outdated juvenile hall and courts facilities. The planning process revealed the need for more than architectural redesign; it called for Alameda County to conceptualize its juvenile justice system differently, to integrate community health care with public safety in a more holistic approach to supporting children and youth who become involved in the system. The result was a collaborative effort led by the Alameda County Health Care Services Agency and County Probation Department to design and construct a new Juvenile Justice Center using an approach based, first and foremost, on an

² *On the Right Track to Safer Communities: Steering California's Juvenile Offenders Away from Lives of Crime*, A report from FIGHT CRIME: INVEST IN KIDS. Oakland, CA: 2007. Page 4. Accessed on the Internet at: <http://67.199.72.34/php/Information/steering.pdf>

³ The Huskey Report is the result of a comprehensive study of the Alameda County Juvenile Justice System conducted in 2004. The recommendations were the inspiration to redesign the JJ system from the inside out, including architecture, intake processing and services, and residential service delivery patterns. Huskey & Associates, Inc. *Alameda County, California Comprehensive Study of the Juvenile Justice System Final Report, Volume 1: Executive Summary and Recommendations*; December 2004. Available on the Internet at: http://www.co.alameda.ca.us/probation/documents/huskey_report.pdf

adolescent health paradigm that promotes treatment, education and the principles of youth development while maintaining a secure environment. The fifty-plus community agencies and organizations that comprised the Alameda County Juvenile Justice Collaborative planning group chose to focus their program design efforts on a commitment to interagency collaboration, alternatives to detention, therapeutic principles, and carefully designed continuity of care. The resulting RFP defined the underlying principles and established standards of care; the planning group selected Children's Hospital & Research Center Oakland and its associated Federally Qualified Health Center (FQHC) to provide health care in the new JJC. Children's Hospital demonstrated particular strength as the provider with the most extensive care network for children and adolescents in the county, and it was well positioned, geographically and professionally, to include juvenile offenders in its treatment mix. Alameda County Behavioral Health Care Services continues to provide behavioral health care to youth inside and outside of detention, through its network of community and school-based clinics, and in coordination with Children's Hospital.

COCHS was established in February 2006 in order to disseminate the concept of creating connectivity between correctional health care and community-based health care. This concept, first pioneered in the mid-1990s in Hampden County, Massachusetts, began with the observation that the overwhelming majority of inmates in the county jail came from only four zip codes and each of those zip codes had a community health center within it. By bringing practitioners from those health centers into the jail, Hampden County was recognizing that the offenders were members of the community who had been temporarily displaced and were likely, within a relatively short time, to return to their community of origin. Their period of incarceration represented an opportunity to link this largely male and minority population with community-based services such as a medical home, substance abuse treatment, and mental health counseling. COCHS is being piloted at seven sites across the US with success on a range of indicators suggesting fewer inmate deaths and suicides, increased public health and public safety in the communities where offenders originate and return to, and reduced violence in jails.⁴

⁴ For more information on COCHS, see the website, www.COCHS.org

Both COCHS and the Alameda County JJC attempt to refocus the lens on both probation and public health by viewing detained individuals as a subset of the larger community, who are temporarily displaced but deserving the same standards and continuity of health care treatment as every other member of the community. JOCHS has adopted this approach as the premise for its work and its three guiding principles that are outlined in Section III below.

Lessons Learned: COCHS and Alameda County

- *Strong local leadership from probation is essential to creating change in the conditions that affect the population of youth and adults it serves*
- *Local public and mental health care providers need education about the health-related needs of the offender population and opportunities to meet these needs*

III. The JOCHS Approach: Community, Connectivity, Continuity

The guiding principles of the JOCHS approach to health care for detained youth are Community, Connectivity, and Continuity. Each component is considered separately here, but ultimately becomes interlinked in the process of creating a continuum of high quality, community-based, physical and mental health services for youth who have contact with the juvenile justice and child welfare systems.

Community

JOCHS brings together partners from county probation and health agencies, community health centers, and other community-based partners on the premise that detainees in a juvenile hall – even if they are not eligible for Medi-Cal or Healthy Families benefits because of “the inmate exception”⁵ - are integral members of the community in which they live. The JOCHS project encourages partners and policy makers to view detention as an opportunity to reshape health care delivery for all children and youth in their jurisdiction and to talk about the local standards and culture of care for those who are not detained as well as for those who are. Detention should not cause juveniles to lose their status as community members or their rights to health care; rather,

⁵ The “inmate exception” is a federal regulation that prohibits Medicaid billing for health care services provided to pre-adjudicated juvenile detainees (U.S. Code § 1396d(a)(27)(A)). For a thorough discussion of this regulation, please reference Burrell, S. and A. Bussiere, “*The Inmate Exception and its Impact on Health Care Services for Children in Out-of-Home Care in California*,” Youth Law Center (November 2002).

when juvenile detainees are viewed as temporarily displaced community members, the local standards and culture of care and standards reasonably apply.

Minimum Standards of Care for Juvenile Facilities

The California Code of Regulations Title 15 “Minimum Standards of Care for Juvenile Facilities” mandates, among other things, the minimum level of health care services that must be provided to detainees in county secure facilities. Title 15 requires that health care services delivered in juvenile detention centers, “... be at a level to address acute symptoms and/or conditions and avoid preventable deterioration of health while in confinement.”⁶ It also allows counties to set higher standards than the regulations require, as long as the standards exceed and are not in conflict with the minimum regulations. The JOCHS approach moves beyond Title 15 and seeks to identify the local adequate and appropriate standard of care for children and youth in the community and apply it to the system of care afforded to youth in detention. Reframed, the Title 15 minimum standard of care may not provide an adequate and appropriate standard of care in a particular community, and the higher standard of care should be delivered within the county to *all* children and youth in the jurisdiction whether they reside within or outside the county juvenile hall.

The Alameda County planning collaborative decided to create opportunities to expand medical and mental health services in its JJC in order to create more parity with the health services available to youth in the broader community.

The JOCHS approach to reshaping health care services for vulnerable youth cannot succeed if it only affects the care offered in detention facilities. Youth who become involved with the juvenile justice system will have health care needs whether they reside with their parents or with guardians, or move in and out of detention, diversion, and placement programs.

As referenced in Section II above, many system-involved youth are afflicted with mental health problems. Research shows that, compared to their peers in the community, “... approximately 20% of the adolescent population suffers from mental health problems, whereas over 50% of

⁶ Article 8 Section 1402(a)(2): Scope Of Health Care, of the California Code of Regulations Title 15, 2007 Revisions, Page 34.

juvenile offenders exhibit some form of mental illness.”⁷ Additional sources report that, even though specific data on the prevalence of mental health disorders among youth in custody is not exact,

Available data suggest that serious biologically based and genetically transmitted mental illness afflicts approximately 20%-25% of the juvenile offender population (Arredondo et al., 2001; Grisso, 2004). Disorders in this population are so severe that the illness significantly impairs home, school, or interpersonal functioning (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). The rates of less dramatic but sometimes equally debilitating illnesses (including post traumatic stress reactions) are considerably higher in these offenders than in non-offending teens, especially in girls (Arredondo, 2002; Steiner & Cauffman, 1998). The prevalence of mild to moderate mental retardation is unknown, but in the experience of specialized courts, is high. Researchers agree that the rate of mental illness seen in the juvenile offender population is at least double that of the general adolescent population, and is likely to be considerably higher (Cocozza & Skowrya, 2000).⁸

A January 2005 study conducted by the Committee on Governmental Reform of the US House of Representatives found that, “The misuse of detention centers as holding areas for mental health treatment is a major problem in California. It is unfair to youth, undermines their health, disrupts the function of detention centers, and is costly to society.”⁹ When counties are considering the health status of their youth populations, they cannot ignore the findings of the research on mental health and its implications for when, where, and how behavioral health services are delivered to youth.

While social justice advocates press for alternatives to detention for youth offenders, JOCHS maintains a focus on addressing the mental and physical health care needs of youth who brought to detention centers. An increasingly common approach to care for at-risk youth is to integrate behavioral and physical health care services in a primary care setting. This method creates a more seamless continuum of care and improves access to mental health services with less stigma

⁷ Cauffman, Elizabeth, Sarah H. Scholle, Edward Mulvey, Kelly J. Kelleher. *Predicting First Time Involvement in the Juvenile Justice System Among Emotionally Disturbed Youth Receiving Mental Health Services*, Psychological Services, 2005, Vol. 2, No. 1, 28-38.

⁸ Behnken, Monic P., David E. Arredondo, and Wendy L. Pakcman, *Reduction in Recidivism in a Juvenile Mental Health Court: A Pre- and Post-Treatment Outcome Study*. *Juvenile and Family Court Journal* 60, no. 3 (Summer). Page 24. For the works cited in the quoted text, please see the endnotes of this report.

⁹ United States House of Representatives Committee on Government Reform – Minority Staff Special Investigations Division, *Incarceration of Youth Who are Waiting for Community Mental Health Services in California*; Prepared for Representative Henry A Waxman; page ii. (January 2005) Accessed on the Internet in April 2009 at: <http://oversight.house.gov/Documents/20050124112914-80845.pdf>

than is traditionally associated with freestanding mental health clinics. Many community health centers have embraced integrated behavioral health care – often including substance abuse treatment. This positions them as natural providers of care to youth who need rehabilitative services to lay a foundation for future success.

“Community” means creating standards and systems that include:

- multiple entry points for care*
- behavioral health assessment and treatment options for youth*
- prevention and education*
- culturally competent health care for all children and youth*

The JOCHS approach recommends that county corrections and health departments convene local stakeholders to assess how well the county is doing in meeting the health care needs of its entire youth population. What services are offered, to whom, and where? Are outreach and prevention activities meeting the needs of adolescents? If asked to envision a health care delivery system that would work well for the entire community, county agencies and stakeholder groups would very likely move beyond “minimum standards” such as those outlined in Title 15. They would choose instead to describe a system that focuses more resources on the needs of youth, integrates behavioral and physical health care, offers prevention and education, provides adequate access to treatment and high quality of care, is culturally competent, and more. They would also be able to identify desirable outcomes, including improved public health, public safety, educational attainment, and cost containment.

Once stakeholders have determined the culture of care that is adequate and appropriate for their community, they will be ready to consider new ways to serve juvenile offenders. By including juvenile offenders as part of the entire community of children and youth, and making connections between the health care offered in detention and the care offered outside, offenders become active constituents in the local culture of care.

The Miracle Question

In Alameda County, the planning group convened to assess the county’s system of care for children and adolescents borrowed and adapted a device used in Solution Focused Brief Therapy called “The Miracle Question.” They asked themselves:

What would the health care delivery system for children and youth in our county look like if we designed it without constraint? How would we know if it were working? Who else would notice the changes and how would they notice it? How would they react? Specifically, how could this vision be made true for juveniles in detention?

Connectivity

Although communities can achieve parity in the standard of health care services for youth inside detention centers and outside in the community by various means, the JOCHS approach promotes a second guiding principle, *connectivity*, as an essential ingredient. When probation agencies engage the services of community health providers that deliver care in the local community, youth have the opportunity to receive the care they need where they need it (in detention and/or the community) and when they need it (before, during, or after detention). Community-based clinics are generally well positioned to connect their services to these youth, and to create relationships that have the capacity to endure when the offenders are released. They can provide assurance to youth that they will continue to see and treat them over time. The JOCHS approach encourages probation agencies to integrate local health service providers in to their systems of care. When a community creates *connectivity*, it is generally creating a higher standard of care for young offenders by moving beyond public safety and Title 15 minimum standards.

Community health providers may be concerned that they are not specifically equipped to serve youth in detention centers; they may be unsure about placing practitioners in a secure facility with a concentration of troubled youth. The safety and security of all residents and staff in the detention center is the primary concern of probation. JOCHS acknowledges that priority and the potential concerns of health care providers regarding safety. In order to address these concerns, probation agencies can seek out providers who are interested in serving juvenile offenders with the same quality with which they serve youth in the wider community, and support their transition to working in the correctional environment. Training in safety standards and measures for working in correctional settings can and should be delivered to these health care providers and would result in appropriate, high quality health services being delivered safely to youth. Title 15 provides a statutory definition of the minimum standards of care for youth in detention

centers *with a primary focus on safety*. However health care providers in detention centers often are contractually bound to comply with certification standards such as those established by the National Commission on Correctional Health Care and/or the Institute for Medical Quality.¹⁰ The JOCHS approach would maintain the safety of staff while raising the standards of health care in corrections to that of the FQHC. Hence, the safety of all staff and youth can be assured along with age- and culturally-appropriate care.

Connectivity requires interagency collaboration to be effective over the long-term. Collaboration between probation and health care providers that begins at the planning stage of the JOCHS approach will establish a collegial framework for the working agreements and contracts, policies and procedures, billing systems, and information and communication mechanisms that will need to be created in the detention center. The JOCHS approach does not seek to deflect accountability away from the county; rather, it seeks to broaden and strengthen the base of support and services to at-risk youth through collaborative efforts of community providers under the leadership of county agencies.

Beyond helping youth, *connectivity* has the potential to yield benefits both for health providers and for detention centers. Community providers who are sensitive to behavioral health issues and age-appropriate development and who are already attuned to the specific needs of at-risk juveniles in their service areas, can establish relationships with juvenile offenders from the initial time of detention in order to observe the full range of emotional and physical symptomatology. In this manner, new opportunities can be created to deliver prevention and education services, and for follow-up treatment upon release. They also may have access to prior health records for some youth, thus promoting more comprehensive, efficient and effective treatment. It is hoped that detainees (and their families) who develop relationships with these providers in juvenile hall will also return to them for their continued mental and physical health care needs after release.

Detention centers benefit from connectivity both in the short and long terms. Probation officers, traditionally charged with maintaining order and security, increasingly are required and are

¹⁰ For additional information on program accreditation in California, please see The Institute for Medical Quality: www.imq.org. For more information on certification programs for correctional health professionals, please see The National Commission on Correctional Health Care: www.ncchc.org

learning to incorporate therapeutic principles in to their interactions with youth. Community providers who know the culture, neighborhoods, and health care needs of local youth are likely to enhance such a supportive treatment milieu in the hall. In the short term, when probation and community providers connect to address the needs of young offenders, a healthier and more secure environment can be achieved. In the long term, *connectivity* also may increase public safety. Juvenile offenders, who are offered the same standard of care delivered to youth in the community, will likely enjoy improved health *and* be less likely to re-offend. This may be most evident in regard to the many juvenile offenders who would receive mental health treatment in detention followed by on-going treatment in the community.

Connectivity sets the stage for young offenders to seek *continuity* of care upon release, the third principle of the JOCHS approach, discussed below.

Connectivity in Alameda County

One of the characteristics that make the Alameda County JJC successful is the unique collaboration achieved by the agencies and supportive service providers that touch the lives of the youth.

The Alameda County Juvenile Justice Collaborative includes Children’s Hospital & Research Center Oakland, the Health Care Services Agency, the District Attorney, the Public Defender, Behavioral Health Services, Probation, Medical Services, Education, and Youth Development providers. They share the goal of working together to support county youth.

The Adolescent Medicine/Teen Clinic at Children’s Hospital provides comprehensive medical, psychosocial and psychobiological services for youth aged 11-19. Children’s Hospital operates an adolescent medicine clinic near the hospital and two school-based clinics in Oakland high schools.

All Alameda County youth, including juvenile offenders, have full access to all of these services in the community.

Continuity

Taken in total, the JOCHS approach intends to help youth offenders establish a stable healthcare home in the community by providing connectivity with community-based services that can support their on-going rehabilitation and development. As the third guiding principle for JOCHS, *continuity* depends on extent of the connectivity between the juvenile detention center and community health providers in each jurisdiction. Constructive interagency collaboration and

positive working relationships will help establish the scope and framework for continuity of care in the community. There are protocols and programming that detention centers can implement to improve this connection.

To increase the likelihood that juvenile offenders engage in programs focused on mental health and rehabilitation during detention and then continue positive behavior upon release, detention centers often develop protocols for re-entry planning. Re-entry planning is a process that ideally begins at intake to the detention center and only ends when the minor is released from custody, when planning ends and integration into the community begins. The JOCHS approach would involve health care providers in re-entry planning beginning with the initial health history and physical exam, and mental health screening. Looking ahead to release, health care providers can develop appropriate treatment plans for youth while they are in detention. Providers can also use the reentry planning process to discuss, encourage, and schedule continuity of treatment in the community, improving the probability that juvenile ex-offenders will use the health and social support services that are available to them after release.

Upon notification to release a youth from detention, juvenile halls generally have a waiting period before actual release from the center into the community. This time can be utilized as the final re-entry planning session with youth and their parents/guardians to review the plans for smoother reintegration into their community. Every effort could be made to dispense information and clarify continuity of care mechanisms. To the extent possible, the re-entry session should focus on continued progress and rehabilitation in the community and should include attention to the following topics:

- Integrated Behavioral Health Care: The re-entry session can be used to schedule appointments for continued mental and physical health treatment and substance abuse treatment programs as planned, to issue medications and prescriptions, and to explain where and how youth can continue to receive the same care and treatments they have received in the hall.

□ Insurance Re-/Enrollment: As previously discussed, under the federal regulation called the “Inmate Exception,” Medi-Cal and Healthy Families coverage is currently discontinued for all youth upon booking into a detention center. Upon release, youth must navigate the process to reestablish their eligibility and to re-enroll. In recognition of the fact that broken coverage can cause delays in treatment and discontinuance of medications, the state Welfare Institutions Code included new language in 2008 that requires counties to assist youth and families in verifying their Medicaid status, determining eligibility, and expediting applications for coverage for those youth scheduled to be released within 45 days.¹¹ Since continued care in the community will require the youth’s ability to access and pay for care, all Medi-Cal eligible youth should be assisted with a streamlined re-enrollment process upon release from detention. As of January 1, 2010, detained youth who are enrolled in Medi-Cal or Healthy Families at the time of booking will be suspended rather than removed from the benefit rolls during the term of detention.¹² Policies and procedures in the detention center should help ensure that enrollment or reactivation in benefit programs occurs immediately upon release.

□ Reproductive Health: California’s FamilyPACT program provides comprehensive reproductive health services to eligible low-income men and women, including teens who do not qualify for public health insurance programs or have private insurance. This clinical program increases access to services through an extensive network that includes medical providers, pharmacies and laboratories. Eligible health care providers in detention centers can enroll eligible youth, provide an introduction to FamilyPACT services, distribute contraceptives, and hand out a directory of youth-focused service providers in the local jurisdiction during discharge planning. Youth are more likely to visit FamilyPACT providers

¹¹ State of California Welfare and Institutions Code Section 14029.5. The specific language can be found on the Internet at: <http://info.sen.ca.gov/cgi-bin/displaycode?section=wic&group=13001-14000&file=14000-14029.5>

¹² The Youth Law Center sponsored S.B. 1147, which requires the Department of Health Care Services to adopt protocols and policies to ensure that Medi-Cal eligible youth are not terminated from coverage, solely on the basis that they are inmates of a public institution. The practical effect of this is to ensure that eligible young people leaving detention facilities do not have to reapply for Medi-Cal -- a time-consuming, onerous process that leaves many without needed prescriptions, mental health services and medical treatment. This bill has been enacted into law and is now Welfare and Institutions Code Section 14011.10. The specific language of the code can be found on the Internet at <http://law.onecle.com/california/welfare/14011.10.html>

when they know exactly where they are located and that they are already enrolled and eligible for services.

- Academic and Job Placement Services: The period can be used to confirm or complete planned school re-enrollment, vocational training, or other alternative educational placement programs to ensure rapid resumption of course work.

The Transition Session at Release from Detention

In Alameda County, each child leaves the JCC having gone through a series of short meetings in the Discharge Planning Center with:

- *a health care worker to provide a complete medical history, any needed medications and prescriptions, a FamilyPACT encounter, and an appointment for follow-up health care in the community;*
- *an academic placement counselor for school reenrollment;*
- *a benefits advocate who assists with enrollment in insurance and other support programs; and, finally,*
- *the probation officer to review the terms of release.*

In addition to re-entry planning, there are other mechanisms and resources that can be put in place to increase continuity of care:

- Contractual Incentives: Community health centers working in juvenile detention have service, mission, and financial incentives to provide a broad and appropriate range of services to their local jurisdiction and the at-risk youth in detention. Counties may have existing contracts and/or an existing set of relationships that may be modified to embed the connectivity approach in such a way as to assure alignment with all the opportunities listed above. The detention center health care providers could be incentivized or motivated to increase continuity of care through creative contractual terms. For example, contracts could be tied to quality outcome measures such as the number of follow-up visits with released offenders within a designated period of time after release, and participation in immunization and disease registries. It is important to remember that each jurisdiction is unique and the types of contractual relationships that are developed will also vary.¹³

¹³ For a more extensive discussion on contractual issues, please see: *Contracting for Health Care Services in Local Jails and Juvenile Detention Facilities: Achieving a Community-Based Standard of Care.* Feldesman Tucker Leifer Fidell LLP for Community Oriented Correctional Health Services, January 2010. Available on the Internet at www.jochs.org.

□ Problem Solving Collaborative Courts: Most often in the form of Mental Health Courts, problem solving collaborative courts offer great promise as both a mechanism for diversion, and an important brokerage mechanism for ongoing care and treatment. Collaborative courts are designed to identify specific populations to serve through defined treatment modalities. With an emphasis on treatment rather than punishment, most are designed as an alternative to detention and have focused on the seriously mentally ill, gender specific treatment, or drug and alcohol services. Essentially, they mandate continuity of care for diverted juvenile offenders. The courts use a multi-disciplinary assessment team to select appropriate youth for assignment to the court, and the bench monitors progress and compliance with evidence-based treatment models. Particularly on the behavioral health side, collaborative courts can help connect youth and their families to community-based treatment resources including community health centers.

□ Conditions of Release: Probation can mandate continued treatment as a condition of release from detention. This approach could be in the form of referral to a specified treatment network, referral to a local behavioral health system or provider, or connection to a health home.

□ Day Reporting Centers: As structured sanction and intervention programs, Day Reporting Centers (DRC) help stabilize youth with attention to their basic needs as they transition back in to their communities, including needs for health care. DRC staff normally work closely with probation officers to:

- Provide clear structure for offenders,
- Provide services that target high risk/high need behaviors such as drug abuse, impulsivity, and anti-social behavior,
- Provide referrals for behavioral and physical health treatment,
- Provide employment and education placement, and
- Compensate for the lack of positive peer or parental support.

Jurisdictions that operate or develop new DRC programs could work together with community clinics to facilitate continuity of health care for juveniles upon release from

custody by providing access to health care on site, transportation to health care services, or other measures that reinforce the importance of health to successful reintegration in school and community.

It is important to note that *continuity* is also individually driven; the extent to which *connectivity* creates options for juvenile offenders when they return to the community will only be as successful as the follow-through by the youth upon release. *Connectivity* that is based on an adolescent health paradigm that builds trust in youth for the providers may stimulate greater continuity of care - as has proven true for adult offenders in the COCHS project – but it does not guarantee it. There are protocols that can be designed and implemented to support continuity of care such as making follow-up appointments during the re-entry session; even so, on-going relationships with health care providers will depend upon the youth’s health needs, satisfaction with previous encounters, access to services, and motivation to seek continued treatment.

Ideas to Jump-Start and Motivate Continuity

- Design the therapeutic milieu in the detention center to promote continuity of care upon release;*
- Support positive interagency collaboration and relationships;*
- Provide assistance to families to apply for or re-enroll all eligible youth in appropriate Medi-Cal, Healthy Families and Family PACT programs upon release;*
- Provide youth and their parents/guardians with a directory of service providers available for continued care. (Alameda County has produced a directory of youth services – it’s likely that many other counties or CBOs have done the same.)*
- Schedule follow-up appointments for youth during transition planning sessions. If appointments are a condition of release, track attendance to probation;*
- Involve Day Reporting Centers in efforts to support continuity of health care;*
- Incentivize providers to continue to provide access for offenders when they return to the community*

IV. Funding Connectivity

The JOCHS’ philosophy maintains that youth in detention are temporarily displaced, and deserve the same opportunities for health care as their peers who reside out in the community; It also incorporates the well-accepted belief that detention for youth should be, by its nature, an opportunity for rehabilitation and preparation to return to the community. In terms of

sustainability, the decision of a county juvenile justice system to adopt a JOCHS' connectivity approach to health care requires upon adequate funding to support it. Behavioral and physical health services that enhance connectivity – and ultimately continuity of care – can be provided to all youth at intake, when young offenders are first brought to detention, and throughout their period of confinement until release. Health care in juvenile justice centers is typically paid for with county general funds. This section of the report outlines some of the potential opportunities and mechanisms for billing to recuperate some of the costs of service delivery. The JOCHS approach emphasizes the importance of delivering Medicaid billable health care services at all points during detention to maximize revenue and improve access to behavioral health services by all detained minors with evidence of need.

Troubled youth often need medical, dental, and mental health care to effectively utilize the rehabilitative programs provided in detention centers. Community health care providers that consistently bill for all eligible services they provide to eligible youth 1) pre-booking at intake, 2) post-adjudication while youth await placement, and, 3) at release/reentry sessions, may generate sufficient reimbursement to cover delivery of these same services to all youth in detention regardless of Medicaid status. Reimbursement also can be maximized with attention given to staffing patterns, efficient and accurate billing, and the nature of services provided.

The Inmate Exception

A factor that prohibits access to most federal funding available for health care in detention centers is the “inmate exception.” In 1997, the Health Care Financing Administration – now known as the Centers for Medicare & Medicaid Services, or CMS – issued a memorandum stating that states and counties cannot receive federal reimbursement from Medicaid or the State Child Health Insurance Program (SCHIP) for care or services provided to pre-adjudicated juveniles in detention. Consequently, states and counties bear the full cost of providing health care to youth in detention facilities.

This exclusion to federal funding participation (FFP) in Medicaid and SCHIP is known as the “inmate exception” and applies to adults but also to juveniles in detention and some other

correctional facilities. The inmate exception does not affect an offender's eligibility for Medicaid/SCHIP; it only affects whether FFP is available.

The inmate exception commences at the time a suspected offender is booked into detention and continues until the petition against the youth has been adjudicated. It also applies while youth are confined, *post adjudication*, in a rehabilitative facility such as a camp or ranch. (See footnote 5 above.)

Despite this restriction, there are opportunities to bill MediCal /Healthy Families and other sources for some health care services at various points along the continuum of contact with a detention center. These billing opportunities and the potential billing mechanisms are described below.

Pre-Booking / Intake Services

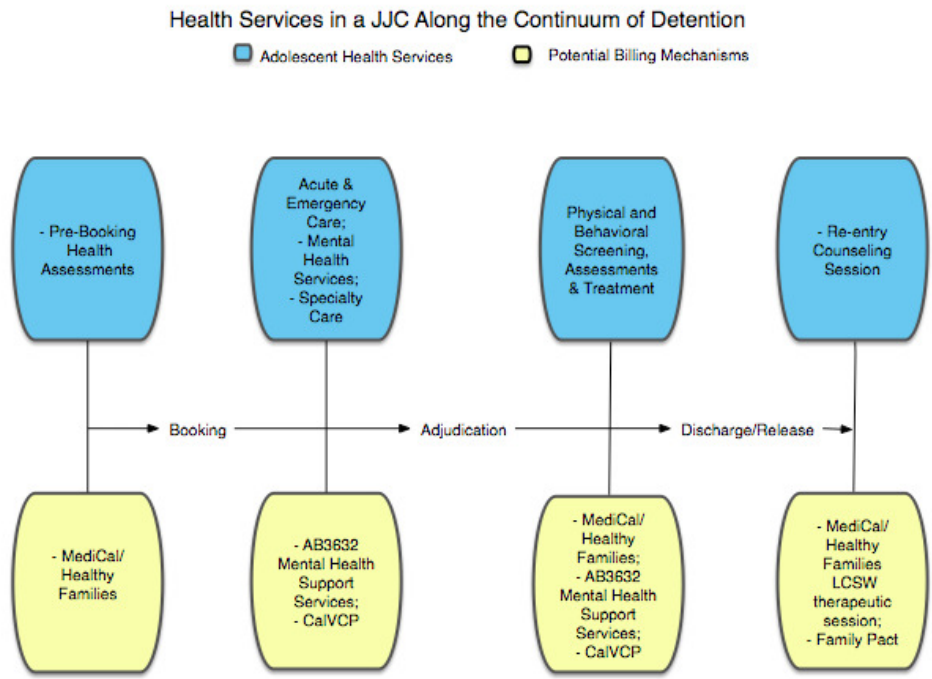
A provider qualified to deliver Medi-Cal eligible services may conduct *and bill for* a health history and physical and other medical and mental health screenings such as STD tests and MAYSI 2 or GAIN assessments *upon intake prior to booking* while Medi-Cal, Healthy Families and FamilyPACT are still in effect. Presumptive eligibility can be inferred for youth with undetermined insurance status, and this will increase federal reimbursement by providing access to the full range of Medicaid and Healthy Families-covered services delivered prior to booking until eligibility is confirmed.

The reason to conduct a physical and mental health assessment of every youth who presents at the door of juvenile hall, regardless of whether they are booked or released, is the value of a risk assessment and the opportunity for therapeutic intervention. If a police or probation officer picks up a suspected youth offender and delivers him or her to juvenile hall, that young person is very likely in need of some form of physical or mental health intervention. Even those youth who are then released without booking - or who, within a few hours after booking, are released to their parents/guardians - represent an opportunity for the county to connect them to community providers who can deliver the youth-focused behavioral, physical, and/or reproductive health services that are indicated by the initial intake exams. It is likely that these youth would benefit

from early prevention, treatment, and community support services to help them avoid future involvement with the justice system. Protocols that include making referrals to local providers can be developed and implemented.

Clearly, youth who are deemed appropriate to detain would also benefit from an immediate assessment and evaluation to shape the initial program services delivered to them in the detention center.

One potential obstacle to conducting the health assessments prior to booking is the architectural configuration of the detention facility. Medical exam rooms may not be located in an area of the facility that is readily accessible prior to booking. Intake protocols and procedures also may need to be modified to expedite the health assessments.



Services for Youth who are Detained

Important opportunities exist for the juvenile justice system to begin and maintain connectivity to the community for youth before their release. An obvious example is the mandate for detention centers to provide appropriate educational services to youth in detention to assure that they can continue academic progress at school upon release. The same rationale applies to physical and mental health care, as discussed above in the sections on *Community*, *Connectivity* and *Continuity*. Prevention, education, and treatment services that are begun in detention help forge a path to continuous care after release.

Under the Youth Bill of Rights, all detained youth in California have the right to “adequate and appropriate medical, dental, vision and mental health services.”¹⁴ Title 15 establishes the minimum standards for delivery of these services. They are typically delivered in the detention facility through medical case management, sick call, and specialty care, with additional hospitalization and mental health crisis treatment as needed. Traditionally, care has often been more reactive than preventive, as it is often limited by county budgets and the inability to bill Medi-Cal or Healthy Families for services delivered to youth after they have been booked, until their petitions have been adjudicated and they are released or awaiting placement.

Where the detention center census is large enough to warrant it, providing specialty care on site may be more appropriate for the adolescent population than transporting youth to off-site providers; fewer off-site transfers may reduce staffing requirements and disruption in the hall. The most typical specialty services provided to detained youth are dental, x-ray and orthopedic, and ob/gyn reproductive health care services.

Although the inmate exception precludes billing for most health services for pre-adjudicated youth, certain sub-groups of youth are specifically eligible to receive services funded by public sources while in detention: minors eligible for services under the Victim Compensation Program (CalVCP); and, youth with documented need for education support services:

¹⁴ The *Youth Bill of Rights* was signed by the Governor and filed with the Secretary of State on October 13, 2007. It can be accessed on the Internet at: http://www.justdetention.org/pdf/legalresources/CA_SB518.pdf

- Victims of Crime: Detention centers may determine whether an offender is eligible for mental health services and/or medical treatment through the Victim Compensation Program (CalVCP) funding streams. Common predictors of such eligibility are involvement with Child Protective Services, gang associations, or witnessing a violent crime. Initial mental and physical health evaluations may identify opportunities for CalVCP treatment while detained in the hall, and following release.¹⁵
- Individualized Education Plans: Another opportunity to support youth in need of services is through documented educational needs. Minor detainees who have a pre-existing, Individualized Education Plan (IEP) have “...specific mental health entitlements under federal and state programs... For instance, a child who is receiving special education and related services is still entitled to receive mental health services that are required for the student to benefit from her special education program, regardless of whether she is Medi-Cal eligible, or enrolled in the Healthy Families program, or if she is insured through a parent's employer-based health plan.”¹⁶

To be eligible to receive AB3632 mental health support services, students must have a current IEP on file. The services must align with the youth's needs as identified in the IEP and be designed so that students will benefit from their designated educational programs. As these services must be made available to all students with documented need, schools in juvenile halls can continue to provide the mental health services that detainees with IEPs have been receiving in their schools in the community prior to detainment. Those youth without IEPs, but whom probation officers or teachers believe could benefit from an educational assessment, could be evaluated in a manner equivalent to youth on the outside. As non-Medi-Cal dependent services, county juvenile detention centers can bill for the AB3632 mental health services they provide to minors in detention.

¹⁵ For information about the State of California Victim Compensation and Government Claims Board, please see it website at: <http://www.boc.ca.gov/victims/default.aspx>

¹⁶ Disability Rights Education & Defense Fund, *Mental Health Services for Children with Disabilities: the Story in California*, funded by The California Endowment, 2001. Accessed on the Internet, April 27, 2009: http://www.dredf.org/publications/ca_endowment.shtml

Awaiting Placement: The subgroup of detained youth who are awaiting placement in a camp, ranch, group home or other rehabilitative facility after adjudication of their petitions may receive full scope Medi-Cal billable services provided they are enrolled in Medi-Cal. For youth awaiting placement and who are enrolled in Medicaid, EPSDT requires - and reimburses - dental, vision, and hearing services, including appropriate screening, diagnostic, and treatment services.¹⁷ Provision of these services establishes a strong motivation for continuation of treatment, perhaps with the same provider, in the community upon transfer to placement. A 2005 study by the Youth Law Center found that California youth offenders with mental health needs were detained an average of 105 days in juvenile hall awaiting placement.¹⁸

Like pre-adjudicated minors, some youth awaiting placement are eligible for AB3632 mental health support services when documented in an IEP, and for therapeutic treatment under the California Victim Compensation Program as described in the preceding section.

Reentry Session at Release

The section on *Continuity* above outlines opportunities and options for detention center staff to facilitate the transition of all youth back to the community. There are at least two funding mechanisms that may be available to support a reentry session for every youth offender and his or her family upon release:

- FamilyPACT, as described above, funds comprehensive reproductive health services, prevention and education for all youth. A billable session would include distribution of condoms or other contraceptives, educational materials, and information on youth-targeted reproductive health service providers in the local community.
- Medi-Cal and Healthy Families can be billed for the services of a licensed clinical social worker (LCSW) who conducts a therapeutic session on reintegration with enrolled youth and his/her family at release.

Maximizing reimbursement for services

¹⁷ US Department of Health and Human Services, Health Resources and Services Administration, at <http://www.hrsa.gov/epsdt/overview.htm>

¹⁸ Sue Burrell and Alice Bussiere, *Difficulty to Place Youth with Mental Health Needs in California Juvenile Justice*, Juvenile Correctional Mental Health Report, Vol. 7, Issue 3, March/April 2007.

The JOCHS project proposes some alternative funding mechanisms for jurisdictions to consider while redesigning their health care delivery system for detained youth including, among others, partnering with a Federally Qualified Health Center to provide care in the detention center, and/or maximizing the use of the Medi-Cal Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Both of these options make use of public funding mechanisms to pay for health care for eligible youth who are brought to detention centers.

Funding connectivity through affiliation with community health clinics and other local partners requires close attention to staffing patterns and to the nature, timing, and location of service delivery in consideration of potential funding mechanisms, the inmate exception, and Title 15. Procedural changes at intake and release designed to increase reimbursement from Medicaid may be relatively easy to implement, while other requirements of compliance that affect billing, such as the architecture of the detention center, may offer greater challenges due to licensure requirements for billable services. Maintaining the safety of youth and staff is paramount to any restructuring of delivery systems, as well. Each facility must be individually assessed.

- Federally Qualified Health Centers: FQHCs are, as yet, untapped resources in regard to the provision of care in youth detention facilities. As safety net providers with substantially enhanced Medicaid reimbursement rates, the compensation they receive for eligible services to enrolled youth may allow them to expand integrated health care services to all youth residing in detention centers. Additionally, they are a natural choice for the provision of continued care in the community for youth upon release from a JJC. Having already developed relationships with youth in custody, they offer a stable healthcare home that is attuned to the needs and culture of youth reintegrating into their service areas. FQHCs can strengthen their connections with at-risk youth and their families - and contribute to increased public health and safety - by developing partnerships with probation.¹⁹

¹⁹ For a more extensive exploration of models that optimize the community-based delivery of health care services to an offender population, please see *Affiliations between Health Centers and Local Correctional Facilities to Provide Continuity of Care for Offenders*, prepared by Feldesman Tucker Leifer Fidell LLP for Community Oriented Correctional Health Services. Available on the Internet at www.cochs.org.

Although local jurisdictions are ultimately responsible for funding the health care delivered to youth in detention, FQHCs that consistently bill for all Medicaid eligible services they provide may generate sufficient reimbursement to cover delivery of these same services to all youth in detention regardless of Medicaid status. It may be useful to consider this approach in phases of implementation relevant to personnel resources, coverage schedules, revenue streams, or other factors.

□ EPSDT: County juvenile justice systems could become more proactive in addressing financial constraints by maximizing the use of the Medi-Cal Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program²⁰, a program that offers reimbursement for therapeutic behavioral services provided to children who qualify for full-scope Medi-Cal. EPSDT requires routine screenings for a variety of potential problems that can help prevent serious and costly conditions and expedite treatment. The treatment component of EPSDT is broadly defined; Federal law states that treatment must include any "necessary health care, diagnostic services, treatment, and other measures" that fall within the federal definition of medical assistance that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services." EPSDT services could be delivered during pre-booking examinations, and, later, post-adjudication, for those youth who remain confined while awaiting placement.

V. Implementing the Vision: How to make the JOCHS Approach Work

²⁰ Medicaid's child health component, known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, is designed to address the physical, mental, and developmental health needs of children and youth under the age of 21 who are enrolled in Medicaid. Since 1967, the purpose of the EPSDT program has been "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected." Screening services "to detect physical and mental conditions must be covered at established, periodic intervals and whenever a problem is suspected. Screening includes a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education. US Department of Health and Human Services, Health Resources and Services Administration, at <http://www.hrsa.gov/epsdt/overview.htm>

Critical to implementing the JOCHS approach is the development of the partnerships and contractual relationships between probation and public health, mental health and/or community health providers to ensure alignment with community standards of care for adolescents.

Although Juvenile justice systems need to meet the minimum standards of care defined by Title 15, they can exceed that mandate and apply higher community standards. Representatives from probation, public and mental health agencies, and community health care providers are encouraged to compare community standards of care for youth with Title 15 mandates, and determine what is feasible for the youth in detention. As discussed previously, these standards will guide the redesign of the juvenile offender health care systems, and, in turn, define the terms of reference for RFPs to solicit bids from qualified health care providers when indicated, and, ultimately, influence all contracts with selected health care providers. Since all communities have different resources to draw upon and will develop diverse approaches to delivering equitable care in and outside the hall, contracts and RFPs will vary between communities.

Some jurisdictions may need to issue an RFP to solicit competitive bids from qualified providers who want to provide services in the detention center. All of these factors will vary according to the local context, but, generally speaking, the RFP should:

- Reflect the community's philosophy towards care;
- Describe the best practices of adolescent health being provided within the community;
- Define how they should be translated to the practices in juvenile hall; and,
- Place emphasis on local providers who will continue care in the community upon re-entry, through clinics and support services accessible to youth.

Whether or not an RFP is required, the resulting contracts that bind all parties in agreements to deliver services in detention according to the three principles promoted by JOCHS will demand the following from health care providers:

- Experience in delivering primary or behavioral care to communities at risk;
- Experience in working with children and adolescents;

- Relationships with other CBOs that serve at-risk youth;
- Ability to comply with Title 15 and other relevant health and safety standards;
- Ability to provide –or partner to provide – dental and reproductive health services;
- Ability to be a collaborative partner in maximizing revenue;
- Ability to do case management and discharge planning where appropriate;
- Ability to provide culturally competent services; and,
- Ability to deliver services in community locations to which youth are returning such as school-based health centers, community clinics, satellite clinics, Day Reporting Centers, reproductive health centers, etc.

The RFP developed by Alameda County and published for local health services providers to generate bids is one example that could provide guidance for other counties. It reflects Alameda’s emphasis on developing alternatives to detention and expanding behavioral health services, topics that may not be the priorities of other counties but that provide an example of embedding community standards into the redesign effort. A link to Alameda County documents can be accessed at www.jochs.org.

Local Leadership

Another key to the successful integration of juvenile offender and community-based health care systems is the political will among stakeholders to identify and to secure the resources to implement the desired changes. Let there be no misunderstanding: additional resources are normally necessary to achieve this level of care for juveniles. Many of the funds may be generated through aggressive pursuit of third-party reimbursement. However, county leadership also may need to obligate local funds to satisfy the difference and/or partner with FQHCs to access increased reimbursement rates. This goal also may require system redesign efforts within the juvenile detention setting in order to maximize third-party payment. (See Section IV, Funding Connectivity, above.)

Training for Health Care Providers

Health care providers who work in juvenile justice centers must have knowledge about adolescent medicine, and skill in delivering care to a population of vulnerable youth, often with

little history of - and tremendous need for - mental and medical health care. Training regarding best practices for the delivery of culturally competent adolescent health care in a secure correctional setting is essential for all practitioners working inside the facility. Community providers who continue rehabilitative care and treatment for youth released from detention will also require similar skill and experience.

***Create a Plan to Define, Fund and Implement the
System of Health Care in the Juvenile Justice Center***

Base the plan on opportunities to create equivalent standards of care for all youth in the community, to assure connectivity to community health providers, and to improve continuity of care for youth before, during and after detention by:

- Establishing collaborative partnerships between providers inside and outside the detention center;*
- Developing a plan for financial sustainability through third-party billing and county revenues;*
- Identifying changes in the processing protocols, service and staffing mix, and/or physical layout of the center that are necessary to meet all criteria for third-party reimbursement from public programs in addition to Title 15 standards of care;*
- Creating a re-entry process that begins with intake assessments and rehabilitative treatment and programs, is punctuated with a transition session at release, and continues as reintegration in the community with local health care, education and support services providers;*
- Establishing mechanisms to streamline and support reactivation of Medi-Cal or Healthy Families benefits for eligible youth upon adjudication, and enrollment of eligible youth upon release for those who were not receiving benefits prior to detention.*
- Delivering training to all health care providers who work in the center regarding best practices, cultural competency, and protocols for delivering care to adolescents in a secure correctional setting; and,*
- Collecting and analyzing data on a variety of measures including services delivered, health outcomes, and continuity of care in the community in order to make indicated adjustments to the program and services.*

VI. Summary Discussion

There are gradients of continuity of health care that can be achieved for youth through implementing the JOCHS approach depending on the array and connectivity of services that youth receive in juvenile justice center. By viewing young people in detention as temporarily displaced members of their communities and the juvenile justice center as one of many places in the community where young people can receive health care, JOCHS intends to help at-risk youth break out of the cycle of arrest and incarceration and to lead better, healthier lives.

We have created a separate correctional system for juvenile offenders based on the simple premise that age affects both culpability and possibility. Embedded in this system is a mandate for rehabilitation and, some would argue, positive youth development. Many young people who are victimized by trauma and poverty have a limited view of the future. For them, without access to a more holistic model of juvenile justice that promotes health along with security, and mechanisms that facilitate community integration, it's really just a question of hope.

JOCHS seeks to fulfill this mandate for rehabilitation through a model of physical and behavioral health that is integrated with security. The potential payoff to society is a more healthy and productive population, a reduction in recidivism, and the fulfillment of a promise to our young people. We offer them an opportunity not just to survive, but also to thrive.

ENDNOTES

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