

## **Juvenile Justice System and Mental Health Policy**

### **Child Welfare Systems Policies and Practices Affecting Medicaid Health Insurance for Children: A National Study**

Libby AM, Kelleher KJ, Leslie LK, O'Connell J, Wood PA, Rolls JA, Landsverk J.  
J Soc Serv Res. 2006;33:39-49.

This study presented national data on financing policies and practices for health and mental health care among children in child welfare settings, including those who are not placed out of the home. Our three objectives were to: examine variation in the provision of health insurance with a specific focus on placement status; describe mechanisms for assuring timing of coverage; and compare Medicaid expansionary practices to innovations in financing and organization of services for youth. Expansionary Medicaid practices were associated with managed care and innovations in the financing and organization of mental health services such as carve-outs.

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### **Delinquent Youth in Corrections: Medicaid and Reentry into the Community**

Gupta RA, Kelleher KJ, Pajer K, Stevens J, Cuellar A.  
Pediatrics. 2005 Apr;115(4):1077-83

In general, states and public agencies acting as custodians for youth in the corrections branch of the juvenile justice system are responsible for ensuring that such youth receive access to timely and appropriate physical and mental health care. However, to date, health care for youth in the juvenile justice system has generally been considered inadequate. Note that in this article "health care" refers to the treatment of both physical and mental health problems. The American Academy of Pediatrics and others have issued policy statements in the past 2 decades that stress the need for better health care for juvenile offenders in correctional facilities. In response, correctional facilities have put in place enhanced acute care services for children and adolescents in juvenile justice.

Although such services are almost certainly needed, these efforts are likely to be deficient on at least 2 counts. First, many of these youth suffer not only from acute medical and psychiatric problems but also chronic ones including substance abuse and other psychiatric disorders. Second, with an estimated 88000 youth being released from juvenile commitment facilities each year, the need for ongoing medical treatment after parole and reentry into the community is high. However, care often stops when the juveniles leave the system, with little or no reintroduction to community services. Pediatricians and other primary care clinicians have a central role to play in

establishing a medical home for these youth and expediting access to critical medical and behavioral services.

This review will provide an overview of the juvenile justice system, present the extant literature on the chronic health problems found in incarcerated youth, and discuss how the absence of care after release from the juvenile justice system impacts public health and society. We argue that Medicaid financing could be used as an immediate measure to ameliorate part of this problem and outline recommendations for future interventions.

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### **Identifying Psychiatric Patients at Risk for Repeated Involvement in Violence: The Next Step toward Intensive Community Treatment Programs**

Skeem J, Mulvey E, Lidz C, Gardner W, Schubert C  
Int J Forensic Ment Health 2002;1(2):155-70

Recent studies indicate that a small, but critical subgroup of psychiatric patients is involved in a disproportionately large number of violent incidents among the mentally ill. This subgroup is an appropriate focus for intensive community-based treatment programs designed to reduce violence. However, little research has been conducted on methods for identifying patients who repeatedly become involved in violent incidents. This article describes a large follow-up study in which these patients were identified using a simple screening process that is feasible for routine use. This screening process efficiently and effectively identified a small minority of patients who were at risk for repeated involvement in violence. Patients deemed “at risk” by the screening process had an average of 7 violent incidents during a six-month follow-up period. The characteristics of these patients are described, and implications of the screening tool for conducting future research, targeting individuals for more intensive treatment services, and developing violence-focused treatment programs are discussed.

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### **Incarceration and Psychotropic Drug Use by Youth**

Cuellar AE, Kelleher KJ, Kataoka S, Adelsheim S, Coccozza JJ.  
Arch Pediatr Adolesc Med. 2008 Mar;162(3):219-24.

**OBJECTIVE:** To determine changes in psychotropic medication use before and after juvenile justice incarceration, contrasting stays in long-stay commitment facilities and short-stay detention facilities.

**DESIGN:** Statewide administrative data (July 1, 1998, through June 30, 2003) from the Florida Department of Juvenile Justice and Florida Medicaid. Medication prescriptions filled before entry and after release from facilities were determined based on paid claims. Psychotropic medication was categorized by drug class based on the National Drug Code. **SETTING:** General community services.

**PARTICIPANTS:** All of the Medicaid-enrolled youth aged 11 to 17 years identified as having a stay in a juvenile justice facility. The total sample included 67 819 detention stays and 59 918 commitment stays. Main Exposure Incarceration in juvenile commitment and detention facilities. Main Outcome Measure Filled prescriptions for psychotropic medication by class 30 and 90 days before and after incarceration.

**RESULTS:** Ninety days prior to detention, 3666 youth (5.4%) had psychotropic drug claims. Among these, 2296 (62.6%) had any psychotropic medication claims in the 30 days after release. Among commitment cases, 29.6% continued medication use after release. Onset of medication use after release from detention and commitment facilities was relatively uncommon (1.7% and 1.9%, respectively). Youth in commitment facilities were less likely than youth in detention facilities to resume their medication use across drug classes after 30 days ( $\chi^2(3) = 6.28$ ;  $P = .04$ ) and after 90 days ( $\chi^2(2) = 7.62$ ;  $P = .02$ ). **CONCLUSIONS:** The results find greater support for a disruption effect than a discovery effect from incarceration. The findings suggest several areas for further investigation and improvement of services for incarcerated youth.

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### **Medicaid Insurance Policy for Youths Involved in the Criminal Justice System**

Evans Cuellar A, Kelleher KJ, Rolls JA, Pajer K.

Am J Public Health. 2005 Oct;95(10):1707-11. Epub 2005 Aug 30.

Juvenile justice and Medicaid agencies share an interest in serving delinquent youths, many of whom have a relatively poor health status. However, many state and local Medicaid policies result in these youths having no insurance coverage, making access to needed services difficult. A nationally representative survey of state and community juvenile justice and Medicaid agencies was conducted to assess Medicaid policies. Evidence from the survey suggests that in some areas delinquent youths are actively disenrolled from Medicaid benefits, and in others little effort is made to connect them to Medicaid coverage. Discrepancies between justice agency and Medicaid agency responses point to poor communication and coordination. Overall, the survey identified several opportunities for policy intervention to enhance access to services for justice-involved youths.

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## **Aftercare Services for Juvenile Parolees with Mental Disorders**

A Collaboration between the Ohio Department of Youth Services (DYS) and Columbus Children's Research Institute

August 29, 2007

Mental disorders among adolescents remanded to juvenile correctional facilities are common, disabling, and expensive. While access to mental health care within youth correctional facilities has improved in certain locales, the linkage of juvenile correctional facility care with community-based services upon release remains anecdotally problematic throughout the nation. This is a critical issue for youths with mental disorders released into the community, as inadequate or interrupted care may lead to abrupt cessation of medications or psychotherapy and thereby increase rates of recidivism. The present study examines the aftercare services juvenile parolees with mental disorders receive as they transition from correctional facilities to the community.

Our three objectives were as follows. First, we assessed rates of recidivism for juvenile parolees with mental disorders. Second, we examined the type and frequency of mental health care received in the community by youths on parole. Third, we investigated the relationship between parolees' recidivism and functional outcomes with their utilization of mental health care. Our ultimate goal is the improvement of treatment services for youths with mental disorders through research on aftercare for youths released from correctional facilities.

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## **Predicting First Time Involvement in the Juvenile Justice System among Emotionally Disturbed Youth Receiving Mental Health Services**

Cauffman E, Scholle S, Mulvey E, Kelleher K

Psychol Serv. 2005;2(1):28-38

Rates of mental illness among youth in the juvenile justice system are exceptionally high, yet the understanding of the process by which some mentally ill youth end up in juvenile justice, whereas others stay in the mental health system is relatively undeveloped. The goal of the present study is to extend previous research findings

Focused prospectively on 659 youth between the ages of 8 and 7 years who were enrolled in Medicaid with a psychiatric diagnosis. Of those with no prior involvement with the juvenile justice system at baseline, 12% had contact with the juvenile justice system within 1 year. Those who were older, exhibited more externalizing behaviors, and came from minority backgrounds were more likely to come into contact with the juvenile justice system. Dual-system involvement was common, suggesting that a more integrated approach between these systems needs to be developed with a special emphasis on minority youth who exhibit externalizing disorders.

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## **Psychiatric and Medical Health Care Policies in Juvenile Detention Facilities**

Pajer KA, Kelleher K, Gupta RA, Rolls J, Gardner W.

J Am Acad Child Adolesc Psychiatry. 2007 Dec;46(12):1660-7.

**OBJECTIVES:** Many adolescents admitted to detention facilities have serious mental and physical health problems. Little is known about policies for the delivery of mental and physical health care in these settings. Our objective was to describe current health care policies in U.S. detention facilities.

**METHOD:** Telephone interviews were requested from 83 juvenile detention facility administrators across the United States. **RESULTS:** The response rate was 97.6%. Data were collected over 12 months, from 2003-2004. Policies for admission health screening existed in 99% of facilities; 90% included mental health screening. Most sites had policies about psychopharmacotherapy and 92% had crisis services. Continuation of existing psychotropic medication treatment was provided at 96% of facilities. Seventy-three percent of facilities used physicians to manage medications in-house; in 61% of the centers, these physicians were psychiatrists. Medication administration policies most often specified nurses, but 16% of facilities used guards. Provisions for discharge psychotropic medication existed at 84% of sites, but there was wide variation in dispensing policies.

**CONCLUSIONS:** Detention health care policies for adolescents have significant gaps, particularly for mental health care. Future research should include an epidemiological study of detained youths, evaluating their health needs and the actual care received.

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