The Indiana State Bar Association

Presents the

Children, Mental Health and the Law Summit:

Official Report on Summit Findings with Recommendations

Fall 2005

Dear Friend,

The Indiana State Bar Association is pleased to issue this report and recommendations from the Children, Mental Health and the Law Summit, held on August 27, 2004, in Indianapolis. The Summit earned the praise of the American Bar Association which awarded the Indiana State Bar Association the Lexis Nexis Community and Educational Outreach Award to recognize the ISBA's efforts in organizing the Summit.

There is growing recognition that juvenile delinquency and the unmet mental health needs of children are linked. This report discusses the extent of the problem, and offers distinct suggestions for effectively improving the lives of children.

On average it costs three times more to house a child in juvenile correctional facilities than to pay for that child to go to school. Under our current correctional system, the mental health and educational needs of juvenile offenders are minimally met, if at all. Child advocates, mental health professionals and juvenile justice officials are recognizing that earlier intervention, before children enter the juvenile justice system, and more effective intervention once children do enter the juvenile justice center, are key strategies to address this growing crisis confronting children.

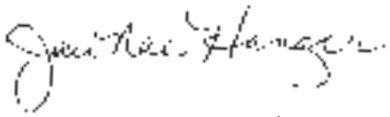
Innovative communities are proving that money can be saved, and juvenile crime can be reduced when the mental health needs of children are addressed. Screening, assessment and treatment, coupled with diversion in appropriate cases, can reduce correctional costs and reduce recidivism rates. Communities throughout Indiana, such as Fort Wayne, Kokomo, and Bartholomew County, are seeing real results in reduced public spending and lower juvenile crime rates.

This report is a synthesis of the interdisciplinary perspectives that were shared at the invitational summit. Over 250 people, from varying disciplines, came together for a day to search for answers, and share their own expertise. These recommendations are offered to contribute to the dialogue that occurred that day, and intended to be shared with policy leaders, in an effort to help address the mental health needs of Indiana children. Summit materials can be found at http://www.inbar.org/content/commitees/standing/CROC/tableofcontents.htm

We wish to acknowledge the many individuals who reviewed the report and made comments prior to its release: James Bell, Indiana State Bar Association Criminal Justice Section; Kristy Bredemeier, Office of Medicaid, Policy and Planning; Gary Chavers, Marion County Prosecutor's Office; Suzanne Clifford, Indiana Mental Health and Addiction; Cathy Graham, IARCCA; Amy Cook Lurvey, Indiana Commission on Mental Health; Kurt Kumli, Santa Clara, CA; Dr. George Parker, Indiana Mental Health and Addiction; Hon. James Payne, Indiana Department of Child Services; Ellen Quigley, Indianapolis Mayor's Office; Lordes Rosado, Philadelphia Law Center; Mary Ann Scali, National Juvenile Defender Center; Russell Skiba, Indiana University Center for Evaluation and Education Policy; and Joesph Tulman, University of District Columbia School of Law. A list of the sponsoring organizations, Summit speakers, and planning faculty is included at the end of this report. We thank the numerous individuals that contributed their time and talents toward the Summit and the eventual release of this report.

Sincerely,

Steven Badger, Chair
ISBA Civil Rights of Children Committee



JauNae Hanger, Immediate Past Chair
ISBA Civil Rights of Children Committee

Indiana State Bar Association
Civil Rights of Children Committee

Official Report and Recommendations Children, Mental Health and the Law Summit held August 27, 2004

"The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country.... Too often, children who are not identified as having mental health problems and who do not receive services end up in jail. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low priorities for resources." Report of the U.S. Surgeon General's Conference on Children's Mental Health.[1]

"We are not a safety net. We are the cold, hard floor that kids hit after every other safety net has failed." Kurt Kumli, Supervising District Attorney, Santa Clara, Calif.[2]

A number of recent studies have shown that children with unmet mental health needs are being incarcerated at an alarming rate. The juvenile justice system is ill-suited, as a matter of both sound public policy and children's civil rights, to be the primary provider of mental health services to children. A lack of prompt identification, diagnosis and treatment of children before their mental health problems lead them into the juvenile justice system, and inadequate screening, assessment and care once they do enter the system are creating a crisis that the legal profession and others cannot ignore.

The failure to act systematically to improve the mental health care of children leads to increased costs over time and diminishes the likelihood of successful treatment of many troubled children. Punishment without effective and appropriate treatment is not an answer. Continuing on that course, which is prevalent in varying degrees throughout Indiana counties, will cause unnecessary levels of harm, violence and recidivism among children in the juvenile justice system, and increasing rates of adult incarceration and spiraling costs in judicial administration and corrections.

Concerns about this situation led the Indiana State Bar Association's Civil Rights of Children Committee, in partnership with the ISBA Family and Juvenile Law Section and the ISBA Criminal Justice Section, to organize an interdisciplinary summit on August 27, 2004. This report outlines specific recommendations developed as a result of that Summit, including steps local communities, mental health officials and the juvenile justice system should consider taking to provide appropriate services to more children with mental health needs, return them safely to their communities and schools and reduce their risk of future incarceration. Indiana has made progress in these areas, but more needs to be done and can be done while at the same time improving public safety.

I. Increasing numbers of children with unmet mental health needs

In recent years, there has been a dramatic increase in the adjudication and incarceration of children. A congressionally mandated study in 1994 confirmed that 690,000 juveniles were admitted to juvenile correctional facilities (detention and correctional placements) nationwide in 1990.[3] One million, eight hundred thousand juvenile cases were filed in U.S. courts in 1996, a 49 percent increase in juvenile cases since 1987.[4] Current figures indicate two million youth under the age of 18 are arrested annually; and, on any given day, more than 100,000 youth are held in detention or correctional facilities.[5] The U.S. Department of Justice has estimated that 40 percent of juvenile cases involve repeat offenders.[6] Over this same period of time, an increasing number of children have been leaving schools, as zero tolerance policies have become more common, and harsher laws affecting children have been passed.[7] These trends have occurred despite national statistics on juvenile crime that indicate a decline in the number and rate of youth arrested for serious offenses since 1993.[8] Moreover, from 1993 through 1999, there has been a 30 percent decline in the total juvenile crime rate.[9] These statistics and trends have important implications for children with mental health needs. Studies have consistently shown that juvenile justice populations experience much higher rates of mental disorders than youth in the general population, and more than half of these children have co-occurring substance abuse disorders.[10]

Though increasingly popular, zero tolerance has not been shown to be an effective approach to enhancing school safety, and there is increasing evidence this approach places students at risk of future delinquency or other negative outcomes. Thus, it is troubling that, according to the most recently available data, Indiana ranks among the states with the highest rates of school expulsion and out-of-school suspension.[11] Studies of school expulsion have documented that many children and youth who are expelled from school have unmet mental health needs.[12] Once expelled, children with unmet mental health needs are at a greater risk of committing delinquent acts. When they are not in school, such students are typically not receiving needed treatment; when left unsupervised in the community, they have greater opportunity to socialize with other troubled youth. The National Mental Health Association (NMHA) has found that children with existing mental health and special education needs suffer the most from zero-tolerance policies and school expulsions. Consequently, the NMHA has issued a policy statement opposing such practices.[13] The NMHA has expressed particular concern about how these children are often placed in environments that are highly structured and restrictive, which worsen their conditions. Similarly, the American Bar Association (ABA) has adopted a position statement that opposes, in principle, "zero tolerance," because such school policies generally end with expulsion, or other discipline, or even juvenile court referral, "without regard to the circumstances or nature of the offense or the student's history." While noting that zero tolerance is theoretically directed at students who misbehave intentionally, the ABA has expressed concern that such policies are also being applied to those who misbehave as a result of emotional problems or other disabilities.[14]

While public policy has shifted during the last few decades to become more punitive for children both in school and in the courts, increasingly larger numbers of children with mental health needs are entering a seriously strained community mental health system marked by chronic shortages of resources and public funding.[15] Given these trends, it is not surprising that similarly large numbers of children with mental health needs are entering the juvenile justice system. Recent studies show that 50 to 75 percent of detained and incarcerated youth in the United States have mental health disorders.[16] Additionally, up to two-thirds of these children have co-occurring substance abuse disorders.[17] Up to 19 percent of incarcerated youth may be suicidal.[18] A recent congressional study has confirmed that there are children in detention centers across the country, and in Indiana, being detained solely because their communities lack appropriate facilities to treat their mental health needs.[19] On any given night, there are on average 2,000 children nationwide held in detention, waiting for community health services.[20] A recent U.S. General Accounting Office report conservatively estimated that, in 2001, parents placed over 12,700 youth into the child welfare or juvenile justice systems in an effort to procure mental health services for them.[21] Seventy-five percent of these placements occurred in the juvenile justice system.[22] Consequently, because of limitations and shortages in community-based care, and an increasingly more punitive approach toward the misconduct of children, the juvenile justice system has increasingly become the "de facto" mental health treatment system for children with mental health needs.

Once in the juvenile justice system, children continue to face fragmented mental health care and widespread deficiencies in appropriate services. Children with mental health or behavioral issues present unique challenges, and they are generally met with a juvenile justice or correctional system that is ill-prepared to handle their serious needs. A series of U.S. Department of Justice investigations has repeatedly found that children in detention and correctional facilities are generally not receiving adequate care for their mental health needs.[23] Those inadequacies continue despite national estimates that approximately 70 percent of detained and incarcerated school-age youth meet eligibility criteria for special education, and up to 65 percent have mental health disorders.[24]

In Indiana, a recent study of state detention facilities by the Indiana Juvenile Justice Task Force indicates that the vast majority of detained youth are not screened, assessed, or treated, and well over 50 percent have mental health and/or substance abuse problems.[25] The consequences for these children can be severe. When children with disabilities go without appropriate services, they may stay incarcerated two to three years longer than other children, and their risk of recidivism increases dramatically.[26] Their conditions often worsen, and their reintegration into the community can be impeded. Because of this increased risk of negative outcomes for these children generally, there is a national movement toward diverting many of them from the juvenile justice system altogether.[27]

Placing children with unmet mental health needs in the juvenile justice system and failing to provide them appropriate treatment causes long-term societal costs, including increased life-long health care costs, increased reliance on public welfare support, and greater costs for the overburdened juvenile and criminal justice systems. The total savings ratio of avoided costs for an adult (including health care savings) has been estimated to be as high as $12 for every $1 invested in mental health treatment.[28]

II. Indiana's progress toward transforming children's mental health care

Increasingly, the Indiana mental health community is viewed as an innovative force working to transform children's mental health care. Despite the growing demand for mental health services among children and the general population and grave shortages in supply of services and funding, Indiana has launched a number of initiatives that have gained national recognition. Considerable progress has been made in establishing systems-of-care teams throughout Indiana counties. These teams provide a

community-based, coordinated network of mental health services for children with serious emotional disturbances and their families. Just recently, Indiana was approved for the Home and Community Based Medicaid Waiver, which allows funding of community-based services for children as an alternative to psychiatric hospitalization. An early-identification-and-intervention pilot program has been established to perform screening, assessment and treatment of children who enter the child welfare system. And efforts have been made to partner with the criminal and juvenile justice systems to enhance training regarding mental illness and addiction, form diversion pilot programs and expand crisis intervention teams to assist law enforcement agencies. Additionally, Indiana has joined a growing number of states that have passed mental health and addiction insurance parity legislation. Along with these considerable statewide efforts, communities throughout Indiana have launched creative initiatives to help provide better access to mental health care for Indiana children. Some of those efforts are mentioned in this report.

Indiana's progress and commitment to transform children's mental health care should be continued and supported at all levels of government. A growing body of data indicates that many programs are effective in treating children with mental illness, inside and outside of the juvenile justice system. The best research-based treatment programs can reduce recidivism and future involvement in the juvenile system by 25 to 80 percent.[29] Treatment success rates for serious mental illnesses range from 60 to 80 percent for adults, when the right combination of medication and other critical services is provided.[30] Likewise, experience shows that the earlier the intervention, particularly with children, the better the result.[31] Thus, in the interests of healthier children and delinquency prevention, mental health care should continue to be strengthened and integrated into primary health care and educational settings, and traditional barriers to care within the juvenile justice system should be identified and eliminated. The recommendations that follow suggest that early intervention, routine screening, assessment and treatment for children entering the juvenile justice system (as well as for other at-risk populations), and diversion of children with mental health conditions into community-based care are key strategies helping children with unmet mental health needs who enter the juvenile justice system in large part because other safety nets have failed.

III. The Summit on Children, Mental Health & the Law: An interdisciplinary dialogue

The Indiana State Bar Association's invitational Summit on Children, Mental Health & the Law at the Indiana Government Center, in Indianapolis, was attended by more than 250 people from across the state. It brought together many diverse organizations and individuals, underscoring the seriousness and breadth of the issues that currently confront children's mental health care in local communities throughout Indiana. Attendees included government officials, legislators, judges, public defenders, prosecutors, probation officers, children's advocates, medical doctors, social workers, educators, child welfare and mental health professionals. More than 60 national, state and local experts spoke on four focus areas: Screening, Assessment and Treatment; Legal Advocacy, Special Education, and Children in the Juvenile Justice System; Juvenile Competency to Stand Trial; and Funding, Building Capacity and Removing Barriers to Service. More than 30 individuals and organizational partners helped plan the Summit, and several legal and non-legal organizations participated as Summit sponsors.[32] Issues were framed in advance of the gathering, and plans were made to produce this post-Summit report, with intentions to distribute it widely to policy makers, advocates and other individuals and organizations throughout the state.

Summit attendees were asked what should happen in the next five years to guide the decision-making of those in policy positions. Several themes prevailed: Delinquency should be greatly reduced. Recidivism rates can and should be decreased significantly. Strategies involving early intervention, special education advocacy, increasing community-based mental health services and diverting low-risk youth with disabilities should be sought as alternatives to delinquency, adjudication and incarceration. For those youth who remain in the system, adequate screening, assessment and treatment should occur in juvenile justice facilities. Educators, mental health professionals, the medical community, the legal community and public officials should collaborate to make this happen. The resulting recommendations below are based on the collective thoughts and perspectives of participants from the Children, Mental Health & the Law Summit in August 2004.

IV. Summit focus areas: Issues and recommendations

The following recommendations are divided into four major categories that correspond to the focus areas developed at the Summit. Issues raised in breakout groups sought to answer the following: (A) Screening, Assessment and Treatment: What is the prevalence of mental health problems among youth in the juvenile justice system; how can detection and treatment be improved in an effort to bring about earlier intervention in individual cases; and how can a standard screening instrument be routinely used to identify and address unmet mental health needs? (B) Legal Advocacy, Special Education, and Children in the Juvenile Justice System: How can the legal system be more responsive to children with mental health needs through representation in juvenile justice proceedings; and how can public education and special education advocacy help children re-enter the educational system, linking them with services to address underlying mental health needs? (C) Juvenile Competency to Stand Trial: What are the issues involved in evaluating juvenile competency to stand trial; what are the implications of the recent Indiana Supreme Court case, *In re K.G.*, establishing that juveniles have a consti-

tutional right to have competency determined before adjudication; and what should the Indiana competency model include? and (D) Funding, Building Capacity and Removing Barriers to Service: How can different funding streams at the state, federal and local levels be leveraged to provide more mental health services for more children; and what can policymakers do to eliminate barriers – statutory, regulatory, policy and budgetary – that impede access to services? The sections Part A through D below briefly discuss the above Summit focus areas, and a series of related recommendations follows each section.

Part A

Routine screening, assessment, treatment and diversion of children with mental health needs in delinquency proceedings

There is a clear link between the prevalence of mental health and substance abuse problems, the economic and practical barriers to mental health services in the community-at-large and anti-social behavior that leads youth into the juvenile justice system. Untreated mental health disorders often affect a child's behavior and have been found to play a key role in affecting delinquency and recidivism. Effective and appropriate identification of juveniles can help prevent youth from entering the juvenile justice system, decrease their involvement in the juvenile justice system and keep detained or incarcerated youth safe.

Indiana has no systematic program or policy to screen, assess and treat children with mental health disorders in juvenile justice facilities. Yet, there has been growing recognition by mental health officials and members of the legal community that routine screening, assessment and treatment of children in the juvenile justice system should take place because of the high prevalence rates of mental health and emotional disorders among juvenile populations. Juvenile detention centers nationally and in Indiana are increasingly exploring strategies that address the mental health needs of juvenile detainees.[33] An important pilot project initiated in Indiana by mental health officials with judicial support has targeted the routine screening, assessment and treatment of children who enter the child welfare system due to child abuse or neglect. This pilot project is envisioned eventually to extend to all youth involved in delinquency proceedings.

The legal community's commitment to extending screening, assessment and treatment of juveniles in delinquency proceedings should continue and be strengthened. A systemized screening assessment and treatment process should be used routinely starting at the point of intake into the juvenile justice system.

An appropriate juvenile justice screening process should be brief and identify individuals with an increased risk of having problems that warrant immediate attention, intervention or more comprehensive review. The screening tool should be tailored to the age of the population and capable of administration by someone with little or no mental health training. Such an instrument is not intended to provide an accurate diagnosis, but rather is to identify those individuals who are particularly at risk and in need of further evaluation. In instances where a mental health disorder is indicated, a more comprehensive evaluation or assessment by a mental health professional should be arranged. There are a variety of screening tools that are available at little or no cost, including for example, the MAYSI-2, which has been adopted for screening youth in detention and correctional facilities in Pennsylvania, Massachusetts and other states.[34]

An assessment is an evaluation process that comprehensively considers specific mental health or substance abuse problems and treatment needs of one person. While particular assessments can be performed to address specific questions about an individual, typical assessments identify psychological needs and offer recommendations for consideration by the court, treating professionals and correctional programs regarding needed interventions. All screening programs should have an assessment component, which ultimately leads to the treatment of youth. Effective screening, assessment and treatment programs can lead to opportunities for early intervention, diversion and reduced future involvement of children with mental health needs in the juvenile justice system.

Recommendations 1–6

Recommendation 1: *A standardized, integrated, statewide program for screening, assessment and treatment of all youth as they enter the juvenile justice system should be developed and implemented.* The first step to addressing the problem of juvenile offenders or detainees with mental health or substance abuse disorders is to screen systematically all youth as early as possible upon intake into the juvenile justice system. Systematic screening using a uniform screening test will help ensure that new detainees are neither a threat to themselves nor to others; it will eliminate selection biases; and it will provide a solid base of information for further study and development of public policy. The information gathered as a result of uniform screening should be aggregated into a statewide database and tracked under a system or protocol that includes measures preserving individual confidentiality and privacy. Youth who are identified with mental health or substance abuse problems should be referred for assessment and treatment, and, when appropriate, diverted out of the juvenile system into community-based care. See Recommendation 3. Individual communities and facilities should be encouraged to develop policies and procedures for screening and assessing youth and then providing appropriate treatment.

Recommendation 2: *Screening and assessment programs should safeguard a youth's constitutional right against self-incrimination.* Juveniles charged with offenses have a constitutional right against self-incrimination. Any program of screening, assess-

ment and treatment of youth entering the juvenile justice system must include protections so that the information is not used to prove their guilt of juvenile delinquent acts or criminal offenses.

Recommendation 3: ***A validated risk assessment instrument should be used in conjunction with screening as children enter the juvenile justice system, and low-risk children with mental health needs should be diverted to community-based treatment.*** An important pilot program shows that the diversion of people with mental illness from the criminal justice system, when coupled with effective treatment, works. The PAIR Diversion Program in Marion County experienced an 83 percent success rate among the 844 adults who participated in the program from October 1996 through December 2003.[35] A similar pilot diversion program should be established for children in the juvenile justice system whose primary needs are for mental health services and who do not pose a threat to the safety of the community. This type of program would be particularly helpful for children with emotional disorders who enter the juvenile justice system because of minor, non-violent or status offenses. The use of a validated risk assessment instrument can help identify children who are found to pose a low risk of harming themselves or others, so they receive community mental health services in appropriate settings. The start-up of such a program could be funded by community correction funds and would eventually help enable local communities to maximize opportunities for Medicaid funding (since Medicaid is generally unavailable for youth placed in correctional institutions).[36] Partnerships should be established with prosecutors in an effort to educate, provide diversion options and encourage treatment in lieu of detention or incarceration. Additionally, child welfare officials and the Indiana Department of Child Services should work with juvenile justice officials to remove traditional barriers that prevent children with unmet mental health needs who initially enter the juvenile justice system through a delinquency proceeding from being removed from that system and placed in the child welfare system to receive appropriate community-based services.

Recommendation 4: ***Attorneys, judges, county and local officials should be educated concerning the mental health needs of youth in the juvenile justice system, the resources and approaches that are available to address such needs, and the benefits of prompt screening, assessment and treatment of mental health disorders.*** Positive outcomes ultimately depend on those at the local level who make decisions affecting youth in their communities. Often there can be resistance to change that comes from outside the local community. For these reasons, outreach should be made to educate local government officials, lawyers, judges, law enforcement and others in the juvenile justice system about mental health disorders and treatment. This should include sharing data from established screening programs that would document the incidence and severity of mental health problems in our juvenile detention facilities.

Recommendation 5: ***Earlier intervention should be encouraged by promoting the use of appropriate screening and assessment methodologies to detect mental health disorders of children in CHINS (Child in Need of Services) cases.*** Frequently, by the time a child with a mental health disorder reaches the juvenile justice system, harm has already occurred to the child and may have occurred to others. Such harm often could be prevented or mitigated with prompt identification, assessment and treatment. Early detection of mental health disorders also maximizes the opportunities for effective and lower cost treatment. Children in the child welfare system are an important juvenile population to target for early intervention. Indiana's pilot project to screen, assess and treat children in the child welfare system should be extended to all counties and made permanent.

Recommendation 6: ***Effective treatment of the child should include efforts to determine and treat mental health needs within the family.*** Often a mental health disorder is affected by the circumstances or conditions in the child's home. Children of parents with mental health and/or substance abuse problems have a heightened risk of developing mental health and substance abuse problems.[37] Merely treating the child without educating and sometimes even treating other family members will not produce lasting results once the child is returned to the home environment. Parents need to be involved in the screening, assessment and treatment process and receive adjunct treatment services when appropriate.

Part B

Special education advocacy to help children in the juvenile justice system

Under federal and state laws, schools have an affirmative obligation to find and identify students with disabilities (including physical, mental, emotional and learning) and determine eligibility for special education and related services.[38] The U.S. Surgeon General has estimated that 5 percent of school-age children have mental disorders and extreme functional impairment.[39] Many more children may have learning disabilities that co-occur with emotional or mental health issues. Yet, less than 1 percent of school age children nationally are identified as needing special education services under the Individuals with Disabilities Education Act (IDEA).[40]

There are a number of reasons why children are not identified, including the family's own hesitancy to label their children "special needs" or "mentally ill," or their reluctance to receive assistance. It may also result from a lack of appropriate programs or sufficient training of school staff to identify these children. This failure of early identification, in which both school officials and families play a vital role, results in missed opportunities to provide prompt and cost-effective treatment and services that could keep

many children with mental health and emotional problems out of the juvenile justice system altogether. The high number of detained and incarcerated children estimated to be eligible for special education evidences missed opportunities for earlier intervention in schools.

Pursuant to the IDEA, children with disabilities are entitled to "a free appropriate public education."[41] Through a mix of mandated federal and state funding, special education and related services are available to eligible students regardless of income level. The IDEA requires educational officials to meet the unique needs of children with disabilities by offering them related services that are necessary for them to benefit from special education.[42] Non-academic services may include counseling, day treatment and attendant care.[43] However, the definition of related services is often quite restrictive for services administered outside of school hours or targeted to support families.[44]

Coupling IDEA and Medicaid to secure comprehensive mental health services for children in schools can help fill the service gaps for many children in need. Although eligibility under Medicaid and IDEA are different, many children with mental health issues qualify for both. Medicaid operates as a low-income health insurance program, with a much broader range of services available, including, for example, home services and behavioral management. In particular, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid provision offers low-income children a strong entitlement to behavioral health services. It requires a state to provide "necessary health care, diagnostic services, treatment, and other measures to address physical and mental illness and conditions."[45] Because of the potential for these two statutes to generate comprehensive community-based mental health systems, school officials should coordinate with other state agencies to use these statutes to provide an array of mental health services for their students through early intervention efforts offered through schools.[46] State and local governments should support local efforts such as these by adopting policies consistent with a long-term, cost-effective view that favors further development of early intervention opportunities and community-based care that is integrated within schools.

Recommendations 7–9

Recommendation 7: ***Special education advocacy within the legal community should be strengthened so that it adequately advances the goal of building and supporting community-based systems of care[47] and protects critical rights of children and parents.*** Achieving a broader, interdisciplinary understanding of the special education rights of school-age children with disabilities among the public, families, school personnel, and medical, mental health, child welfare and juvenile justice professionals is an important strategy in preventing special needs children from entering the juvenile justice system. During the last 40 years, educators, parents and advocates have made considerable progress in furthering school programs that serve children with disabilities. However, there are still important opportunities for creating a cross-disciplinary approach so that more children with mental health needs receive treatment that will help them to stay out of the juvenile justice system. Educators should ensure that reader-friendly versions of special education law[48] are available to parents and families, and that local school staff receive adequate training on special education law. A broad-based understanding of special education law by the legal and medical communities should also be fostered. Attorney training programs in special education advocacy should be strengthened; and those working in the juvenile justice system, including law enforcement officers, juvenile detention center staff, probation officers, public defenders, prosecutors, judges and correctional facility staff, should be trained well enough to achieve a cross-disciplinary understanding, so that children with special needs or disabilities are ultimately placed in appropriate treatment settings and kept out of the juvenile correctional system when community-based care is appropriate. Also, efforts should be made to increase parents' and the medical community's awareness of and access to legal resources that can benefit children with unmet mental health needs.

Recommendation 8: ***Efforts should be made to increase the availability of prevention, early intervention and special education alternatives for children with unmet mental health needs in order to reduce school expulsions and out-of-school suspensions.*** There is an emerging consensus that pro-active interventions focusing on prevention and early intervention are much more likely both to meet the needs of at-risk youth and reduce school violence and disruption.[49] Strategies should be developed regarding how to bring services (health and mental health) into more schools, so that children having problems can be identified early, before expulsion. School programs targeting children at risk of expulsion should be developed to screen, assess and treat children with mental health needs. Increased efforts should be made to link counselors with truancy, family preservation and mental health options in the community.

Recommendation 9: ***Efforts should be made to increase the use of IDEA and Medicaid entitlements to generate comprehensive community-based mental health systems that are integrated in schools to provide mental health services for school-age children through early intervention efforts.*** See also Recommendation 18. Major health care providers, the Indianapolis Public School System and Learning Well, a local organization whose mission is to coordinate school clinics throughout Marion County, have taken significant steps toward integrating physical and mental health care in the lives of school-age children through the operation of school-based clinics. Such clinics should be made available in other school systems throughout the state. Vermont is a good example of a state that has successfully used IDEA as an important adjunct to Medicaid in order

to provide school-age children with school-based health clinics. In Vermont, the school systems paired IDEA funding to the state Medicaid match in an effort to fund 300 school-based clinicians. The state's mental health centers participate in providing services once children are identified under IDEA.

Part C

Ensuring juvenile competency to stand trial

Many juveniles facing delinquency charges are not competent to stand trial. Adolescents in the juvenile justice system are disproportionately of below-average intelligence and likewise disproportionately have serious mental illnesses. The results of the Juvenile Competence Study by the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice suggest that about one-third of 11- to 13-year-olds and one-fifth of 14- to 15-year-olds overall lack the ability to understand the charges against them, to assist in their own defense or to weigh the consequences of decisions such as waiving rights.[50]

The MacArthur study shed new light on the issue of juvenile competency to stand trial. The study was focused on the legal standard for competency to stand trial: that is, whether the defendant has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and whether the defendant has a rational as well as factual understanding of the proceedings against him. Competency is not a constant or permanent condition, as it can often be modified. Nor is competency a question of criminal responsibility, culpability or blameworthiness.

The basic research question presented in the MacArthur Study was whether adolescents differ from adults in their ability to participate as defendants in trials. Then, if they do differ, what types of children manifest significant differences from adults? If there are deficits, what kinds of deficits in their abilities are most relevant for law, policy and practice? The findings were alarming. The MacArthur study found that 20 percent of 14- to15-year-olds and 33 percent of 11- to 13-year-olds manifest deficiencies in understanding and reasoning comparable to mentally ill adults who are incompetent to stand trial. There was no significant difference between adults and adolescents ages 16 and older in these abilities, and there was a strong correlation with intelligence level and age. The risk for incompetence is especially apparent among juvenile offenders with a below-average IQ. The results were not explained by gender, ethnicity or socio-economic class.

Indiana statutory law does not specifically address juvenile competence to stand trial. In juvenile court, there are statutes allowing for emergency psychiatric treatment, but not for determination of competency. In May of 2004, the Indiana Supreme Court addressed the issue of juvenile competency to stand trial in the case of *In re K.G.*[51] The Court held that juveniles alleged to be delinquent have a constitutional right to have competency determined before they are subjected to delinquency proceedings. The Indiana Supreme Court's holding applied the general "adult" standard for competence to juveniles. This standard asks "[w]hether the defendant has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, and whether he has a rational as well as factual understanding of proceedings against him."[52] The Court also held that the adult competency statute, requiring commitment to the Department of Mental Health upon a finding of incompetency, did not apply to juveniles, thus leaving children in the juvenile justice system.

Although the *In re K.G.* decision affirmed that Indiana children have a fundamental right to competency to stand trial, children who are found to be incompetent are currently left adrift in the system, with many questions left unanswered. For instance, there is no process in place to determine competency, restore juveniles to competency, or determine what to do with juveniles who cannot be restored. Further, Indiana's response to the issue of juvenile competence to stand trial must answer some basic questions such as: How should incompetent juveniles be identified? What services ought to be provided while a juvenile is deemed incompetent? And, what do we do with those children who cannot be "restored?" There are additional juvenile justice issues implicated by the MacArthur Study results as well: raising the age threshold for transfer to criminal court; requiring competencey evaluations for youth under a certain age before transfer to adult criminal court; and referring juvenile delinquency cases involving incompetent youth as CHINS cases.[53]

Recommendations 10–14

Recommendation 10: A *collaborative, interdisciplinary committee, to be appointed by the Indiana Supreme Court, should recommend processes for: (1) determining competency to stand trial in juvenile delinquency proceedings; (2) restoring children to competency; and (3) determining what to do with children who cannot be restored.* The committee should include, at a minimum, representatives from the following: juvenile court judges, legislators, prosecuting attorneys, public defenders, the Indiana State Bar Association, the Indiana Division of Mental Health and Addiction (DMHA) and the Indiana Department of Child Services. The committee should submit a final report to the Indiana Supreme Court that would include points addressed in Recommendations 11-14.

Recommendation 11: *An Indiana juvenile competency model should be based on the same legal standard for competency required in criminal court, as set forth in* In Re K.G. The *Dusky* standard constitutionally requires that a criminal defendant may not be subjected to a trial unless he has the capacity to understand the nature and object of the proceedings against him, to consult with counsel and to assist in his defense.[54] The Indiana Supreme

Court in *In re K. G.* held that due process requires "competence to understand the nature of the charge and to assist in a defense" in juvenile proceedings.[55] This competency standard affords important constitutionally mandated safeguards, particularly for juveniles facing potential waiver to adult court or harsher sanctions. As Indiana develops a process for determining competency to stand trial in juvenile delinquency proceedings, the definition of competence should be the *Dusky* standard.

Recommendation 12: ***Competency evaluations should be required, unless waived by the child's counsel, in cases where the State is seeking waiver to adult criminal court.*** A child waived to adult court is an adult for all purposes, including sentencing. Given the risk of a juvenile facing the potential of an adult prison sentence, mandatory competency evaluations are a necessary safeguard to ensure these juveniles have the capacity to understand the proceedings against them, consult with counsel and assist in their defense.

Recommendation 13: ***Legal counsel should be appointed in every juvenile delinquency case to help ensure that juveniles are not subjected to delinquency proceedings if they are incompetent to stand trial.*** Juveniles have a statutory and constitutional right to counsel in delinquency proceedings. How counsel is appointed varies from county to county, and, in practice, many juveniles proceed without representation. Many of these juveniles may not be competent to waive their constitutional right to counsel. Requiring legal counsel to be appointed in every juvenile delinquency case would help ensure that juveniles are not subjected to delinquency proceedings if they are incompetent to stand trial.

Recommendation 14: ***A child found to be incompetent to stand trial, who is incompetent due to mental health issues rather than due to age and development, should be referred to the county office of the Department of Child Services to receive services as either a CHINS (Child in Need of Services) or pursuant to I.C. 31-34-1-16, which would allow for services without parents relinquishing custody of their child.*** The provision of necessary mental health services could then be made available in addition to restoration services. If a child is not restored to competency within a specified time period, the delinquency petition should be dismissed. Treatment for children with mental health issues should not be delayed while restoration services are provided. If the child is in need of services or treatment, this could be accomplished through a parallel CHINS process while restorative services are being provided through the pending delinquency proceeding.

Part D

Funding, building capacity and removing barriers to services

A major barrier to the access of mental health care is the lack of adequate funding. Funding issues arise in part because of under-funded programs, varying eligibility requirements for programs and a lack of understanding and agreement on who should pay for services among governmental agencies at both the state and local levels. How these issues are resolved at the local level often determines which children receive services. Funding constraints also arise from the present allocation of resources. The failure to fund mental health care and special education at adequate levels sustains a system that unintentionally fosters higher costs associated with recidivism and increasing rates of juvenile, and eventually adult, incarceration.

Strategies to enhance funding should include: pursuing cost-effective measures, such as early intervention and diversion of low-risk youth to community-based services; removing legislative and administrative barriers preventing the pooling of existing sources of federal and state money and undermining inter-agency and local-state collaborative efforts to fund services for children; leveraging state and local money with federal money to maximize available funding for children's mental health care; and eliminating other legal and regulatory barriers that impede the ability of communities to provide adequate services at the local level. Funding programs and administrative requirements should encourage and promote prevention, early intervention, diversion of low-risk children, and use of community- and home-based services for children with mental health needs. Ultimately, such a policy would shift costs from juvenile justice, criminal justice and corrections, to community-based mental health care, and would help reduce system-wide costs through lower rates of juvenile and adult incarceration and recidivism.

Strategies should be explored to maximize federal funding and to leverage federal match programs with state and local monies to help pay for children's mental health needs in the juvenile justice system.[56] Local counties should share in the responsibility of ensuring that cost-effective and revenue-enhancing strategies are pursued at the state and local level. County officials should understand how to appropriately maximize federal Medicaid money because local funds can serve as the state's match under the federal Medicaid program.[57] Counties should use federal, state and county monies efficiently and cooperatively, in an effort to treat children more effectively.[58] School officials, mental health providers, medical professionals and officials from the Indiana Division of Mental Health and Addiction, Indiana Department of Child Services, the Office of Medicaid and the Department of Correction Community Correction program should collaborate with juvenile court judges and other juvenile justice officials to ensure that the funding of mental health needs of children in the juvenile justice system are met at the local level. This collaborative model should be carried over to the state, requiring agencies to develop joint policies, budgets and plans that provide flexibility and technical assistance on funding issues to counties.

Recommendations 15–21

Recommendation 15: ***Inter-agency funding should be service driven at the local level, and mental health services should be easily accessible by families and children.*** Over a decade ago, the Indiana Division of Special Education helped lead efforts that now allow the "wrap around" service model as an option for local communities to develop community-based placements and avoid expensive out-of-state placements. Today, there are less than a handful of children who are placed in out-of-state facilities. Models of successful wrap-around programs include the Dawn Project in Indianapolis and Circle Around Families in Gary, both benefactors of Indiana's early efforts at collaborative inter-agency funding. Over half of Indiana counties have organized wrap-around systems-of-care. These efforts to use different sources of money to leverage services should be continued and should build on Indiana's innovations in this area. Where possible, restrictive regulations prohibiting the effective use of different sources of program money should be changed to allow flexibility among different funding sources in individual cases. Successful systems found in other states have integrated funding in a common plan for families and children and coordinated the delivery of services through a single accountable entity, with various agency programs contributing resources.[59] A few examples of state-level funding initiatives outside Indiana include New Jersey (innovative statewide financial management system that creates a flexible pool of funds available for children's services), Vermont (blends funds to operate a comprehensive immediate-response system throughout the state), and Michigan (uses a wrap-around approach in 17 counties).[60]

Recommendation 16: ***Additional revenues should be identified for children's mental health services.*** While state and local officials should effectively use relevant funding sources—local, state and federal—the need to identify new sources of money should not be ignored if other revenue enhancements fall short of addressing the mental health needs of children. Redirecting existing funds from correctional to community-based care, identifying greater collaborative efficiencies at both the state and local levels, leveraging federal dollars with state and local funding, and considering different taxes or tax structures should all be pursued. Also, strategies should be developed that transition funding in juvenile justice and corrections to early intervention, diversion and treatment. There should be recognition by state policy-makers, legislators and local officials that cost-shifting will have to occur in order to fund adequately special education and mental health services. The investment that takes place in education and public health will yield considerable savings in both the short- and long-term in juvenile justice administration and corrections.

Recommendation 17: ***Medicaid eligibility should be maximized by limiting placements of children with mental health needs in secured settings to those children who cannot be appropriately treated through community-based services.*** Whether children in the juvenile justice system are eligible for Medicaid may depend on where they are placed. Medicaid benefits are not available to children placed in detention centers, jails and correctional facilities.[61] For those children, the state and local communities bear the entire cost of treatment, or their needs go unmet. In order to maximize federal funds under Medicaid, the removal of low-risk children with mental health needs from state and county correctional systems should be a priority. Savings from state and local corrections could then help fund increased community care options, and the increased availability of Medicaid dollars could help maximize the leverage of state and county funds with federal funding. Current fiscal policies and funding relationships between the county and state encourage the juvenile justice system to shift placement of children in need of services from county to state correctional facilities. Such policies should be changed to support placement decisions based on the assessed risk of a child and treatment considerations in appropriate placement settings. Also, the state should consider adopting an interpretation of Medicaid law that suspends, rather than terminates, benefits while a juvenile is placed in a detention or correctional facility, or in an adult jail, in order to minimize activation time after the child's release from a secured facility. Additionally, to ease transitions in care, discharge planning that is currently being done in state psychiatric hospitals should be replicated by state and county correctional facilities.

Recommendation 18: ***Mental health care benefits for low-income children should be maximized through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid funding, as well as through other under-utilized federal funding programs.*** Indiana should maximize the use of EPSDT Medicaid funding to ensure provision of services for children with mental health needs.[62] Local officials, educators, service providers, attorneys and juvenile court officials should understand how to access this funding for at-risk children or children in the juvenile justice system through the use of early intervention and juvenile diversion strategies.[63] Efforts to use IDEA and Medicaid together for developing system-wide approaches to delivering services to children should be pursued. See Part B.

Recommendation 19: ***Sufficient funding should be provided for building greater capacity of community-based services and for dissemination of information on evidence-based, best practices.*** Programs providing technical assistance regarding funding issues and the dissemination of information on best practices should be developed and supported by state and local funding. Integrating mental health services into primary health care, and employing more mental health professionals at the local level to increase access to mental health programs are important strategies for building capacity and improving service delivery to families and children.

Recommendation 20: ***Local communities and counties should consider developing inter-disciplinary alternatives to encourage cross-coordination of services for youth in the juvenile justice system.*** Innovative models for cross-coordinating service delivery to children can be found operating in several local communities in this state, and at a national level. For example, Monroe County has facilitated an inter-disciplinary approach by developing the position of a youth placement coordinator as an alternative to the traditional probation officer. The youth placement coordinator oversees services delivered to children, brings together different perspectives, and facilitates communication among different agencies and professionals providing services. In another example, in Porter County, the juvenile court is directly involved in accessing the service system and eliminating obstacles to services through the use of a local coordinating committee, which involves families and local service providers. In Marion County, the Dawn Project, an innovative wrap-around service program, has gained national recognition as an effective program for juvenile justice youth. At a national level, Santa Clara County has developed the nation's first juvenile mental health court. Operating since 2001, the juvenile mental health court has successfully achieved a partnership among judicial officers, prosecutors, public defenders, mental health coordinators and probation officers to provide more community-based options and humane treatment of juveniles with serious mental illness.[64] In its short existence, the court has achieved a reduction in recidivism for youth who participate in the program of 7 percent, as compared to 25 percent for the general juvenile population in that county.[65] Other states that have established juvenile mental health courts include Florida and Ohio. County officials and local juvenile justice officials should explore these and other innovative models and collaborate with others in their communities to provide children with cross-coordinated care.

Recommendation 21: ***Policies and laws should be adopted or changed to improve collaboration, coordination and information-sharing among education, mental health, medical, juvenile justice, foster care, residential treatment programs and public/private child welfare professionals.*** Currently there is a lack of sufficient collaboration and information-sharing among agencies and professionals across the educational, mental health, medical, child protection and juvenile justice systems. Frequently, legal barriers—either statutory or administrative, real or perceived—impede collaboration and communication among these groups of professionals. For example, the sharing of medical records can be difficult because of actual and perceived barriers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[66] Barriers such as these that make collaborative approaches difficult should be identified and addressed. At the same time, safeguards must be put into place to protect youth's constitutional right against self-incrimination. See Recommendation 2.

V. Other areas of concern and potential legislation

The recommendations below consider additional policy areas that are implicated by the dialogue of addressing the unmet mental health needs of children. They recognize the need to provide an effective continuum of mental health care for children placed within correctional institutions and the importance of removing barriers to care that arise from shortages of private provider care at the local level. There also should be continuing juvenile jurisdiction when children with disabilities are placed within state correctional facilities, to help ensure that their needs are not overlooked. The last recommendation suggests that this interdisciplinary discourse should continue at the highest levels of government, so that the current momentum for meaningful change continues for Indiana children.

Recommendations 22–25

Recommendation 22: ***Legislation should be considered requiring timely and appropriate mental health treatment and services for juveniles and their families secured or incarcerated in the juvenile justice system.*** Each juvenile detention center or correctional facility should be required to provide appropriate mental health staff, through public or private providers, including child psychiatrists, proportionate to the effected population in each facility. Only skilled mental health providers or trained staff should provide mental health services to youth in the juvenile justice system. Providers should use evidence-based treatment practices; case managers should link juveniles to services in the community; families should be involved in mental health care decisions; and adjunct treatment should be provided to family members, when needed, for youth re-entering the community. Also, detention and correction facility staff should link the juvenile with appropriate after-care services in the community.

Recommendation 23: ***Policies should be developed to remedy the negative impact that inadequate insurance and Medicaid reimbursement levels have on the availability of mental health services in the private sector.*** Medicaid regulations and reimbursement policies, and the reimbursement policies and limitations of private insurers, have had a negative impact on the profitability of private mental health service providers. Currently there are not enough mental health services to meet the immediate demands of Indiana communities. A dialogue should be held among government agencies with medical professionals, community mental health providers, universities, private hospitals and treatment facilities to identify specific measures which can be undertaken to increase the supply of mental health services throughout the state. Shortages in children's mental health professionals, including child psychiatrists, psychologists and mental health case managers should also be addressed. State officials

should increase collaboration with universities and the private health care sector, to expand the workforce.

Recommendation 24: ***The jurisdiction of the juvenile court should be extended to allow monitoring of children with disabilities who are placed in state correctional facilities.*** With the exception of repeat truants and runaways, Indiana law provides once a child is committed to the Department of Corrections, the juvenile court no longer has jurisdiction.[67] An exception for children with disabilities would allow the juvenile court periodically to review the child's progress and would provide a means to modify the disposition if the commitment is no longer serving the child's or society's best interests.

Recommendation 25: ***The work of the Summit should be continued.*** A broad-based, interdisciplinary children's standing committee should be formed, possibly organized under the Indiana Commission on Mental Health, to advise the legislature, the Governor, agency program heads and local officials on how to strengthen, in the short- and long-term, the state's mental health and substance abuse services for youth and their families throughout Indiana. The committee should be comprised of children, mental health and disability advocates; public and private service providers, including community mental health, substance abuse and residential treatment providers; and state and local officials in health care, mental health, education, social services and juvenile justice. It should review model or exemplary child mental health service systems in Indiana, and across the country, such as those found in Milwaukee, Philadelphia, New Jersey, Vermont, Michigan and Virginia, and make recommendations regarding potential state innovations. It should also help monitor and assess the state's progress toward affording all Indiana children early and affordable mental health care.

Footnotes

1. U.S. Department of Health and Human Services, Report of the U.S. Surgeon General's Conference on Children's Mental Health, Washington, D.C. (2000 Report) (available at http://www.surgeongeneral.gov/topics/cmh/childreport.htm).

2. Kurt Kumli, Keynote Address: Children, Mental Health and the Law Summit, Indianapolis, IN (August 27, 2004).

3. David W. Kaplan, et al., Health Care for Children and Adolescents in the Juvenile Correctional Care System, American Academy of Pediatrics, V. 107.4, 799, April 2001 (citing Parent, D.G., Conditions of Confinement: Juvenile Detention and Corrections Facilities. Research Summary, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, Washington, D.C., 1994).

4. Id. (citing H.N. Snyder and M. Sigmund Juvenile Offenders and Victims: 1999 National Report, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, Washington, D.C., 1999).

5. Data provided by the National Center for Mental Health and Juvenile Justice (2005).

6. Id. (citing H. N. Snyder, Juvenile Arrests, 1996, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, Washington, D.C., 1999).

7. A large percentage of public schools employ zero-tolerance policies for certain student behavior. A governmental survey in 2002 confirmed that 79 percent of the nation's public schools have zero-tolerance polices to address violence and tobacco use; and 94 percent have such policies to deal with weapons. Definitions vary from school to school, with some more stringent than others. Jill F. Devoe et. al., Indicators of School Crime and Safety: 2002, U.S. Departments of Education and Justice, Washington, D.C., 2002. Throughout the last several decades Indiana's adult transfer statutes have grown through statutory exclusions, including drug offenses and weapon possession. I.C. § 31-30-1-4. Also, Indiana is one of 31 states that have "once an adult, always an adult" provision. I.C. § 31-3-3-6 and § 31-30-1-2.

8. H.N. Snyder and M. Sickmund, Juvenile Offenders and Victims, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, Washington, D.C., 1999.

9. Id.

10. National Mental Health Association, Prevalence of Mental Disorders Among Children in the Juvenile Justice System (2001).

11. Russell Skiba, M. Karega Rausch and Shana Ritter, Children Left Behind: School Suspensions and Expulsions in Indiana, Education Policy Briefs, Vol. l. 2, Center for Evaluation and Education Policy, Indiana University, 2004. In addition to examining national data showing a lack of evidence for the effectiveness of zero tolerance, the report presented data from the 2000-2001 school year from the U.S. Department of Education, Office for Civil Rights, showing that Indiana ranked first in the nation in school expulsions, and ninth in out-of-school suspensions.

12. Gale M. Morrison et al., School Expulsion as a Process and an Event: Before and After Effects on Children At-Risk for School Discipline, Univ. of Calif., Santa Barbara, CA (2001).

13. National Mental Health Association (NMHA) Position Statement Opposing the Blanket Application of Zero Tolerance in Schools (Adopted June 8, 2003).

14. ABA, Report to House of Delegates, 103 B, February 2001. The ABA's position statement on zero tolerance not only notes the disproportionate impact zero tolerance has on children with disabilities, but also on students of color, which, for both reasons, contravenes ABA anti-discrimination policies. The ABA report notes, pointing to a study conducted of ten school districts in 1999, that black students are being suspended or expelled at higher rates than their peers, and were thus suffering the most under new "zero-tolerance" policies. Moreover, such policies are at odds with the Individuals with Disabilities Education Act (IDEA), which requires "the need for individualized attention to needs and behavior of students with disabilities whose responses in certain situations may be misinterpreted as disciplinary problems."

15. National and state prevalence rates of mental illness support that the demand for mental health/substance abuse interventions far exceeds the current supply of services. The U.S. Surgeon General has estimated that 75-80 percent of children with mental and behavioral issues fail to receive appropriate services. U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, 1999. Suzanne Clifford, Director, Division of Mental Health and Addiction, presented data to the Indiana Commission on Mental Health in September 2004, indicating that the annual number of people served by the Division of Mental Health and Addiction had doubled over the last ten years, despite strained state and federal budgets; and, as a consequence, resources to treat children who are actually in the community mental health system are severely strained. For instance, in 2004, HAP (Hoosier Assurance Plan) average funding per child with serious emotional disturbance was $500, even though the cost of minimum services was estimated at $2,000 per child.

16. Linda A. Teplin et al., Psychiatric Disorders in Youth in Juvenile Detention, Archives of General Psychiatry, 59(12): 1133-1143 (December 2002).

17. National Mental Health Association, Mental Health Treatment for Youth in the Juvenile Justice System; A Compendium of Promising Practices, 1, 2004; see also, supra note 10.

18. Id.

19. Over a six-month period, 15,000 children in 49 states were held in detention centers, simply because they were waiting for mental health services. U.S. House of Representatives Committee on Government Reform-Minority Staff Special Investigations Division, Report: Incarceration of Youth Who Are Waiting for Community Health Services in the United States, prepared for Rep. Henry A. Waxman and Sen. Susan Collins (July 2004).

20. Id.

21. Supra note 5.

22. Id.

23. Id.

24. Peter E. Leone, et al., Understanding the Over-Representation of Youths with Disabilities in Juvenile Detention. D.C.L Rev. 3(Fall), 389-401, 1995.

25. William N. Glick & Mistie Morales, Indiana Juvenile Detention Mental Health and Substance Abuse Assessment Project (summary statistics) (2004).

26. Joesph Tulman, University of District Columbia, David A. Clarke School of Law, Presentation Prepared for the Children, Mental Health and the Law Summit: Special Education Advocacy for Young People in the Delinquency and Criminal Systems, Indianapolis, IN (August 27, 2004) (available at http://www.inbar.org/content/news/article.asp?art=339). Children with disabilities are 200 percent more likely to be arrested than the general juvenile population due to a variety of reasons related to their disabilities, including their inability to cooperate and the failure of the system to perceive their disabilities and respond to them. Similarly, at the trial stage, children with disabilities are 220 percent more likely to be adjudicated; and at disposition, their terms of incarceration and/or probation average 2 to 3 years longer.

27. Supra note 5.

28. Suzanne Clifford, Director, Division of Mental Health and Addiction, FSSA, Report to the Indiana Commission on Mental Health: Mental Health and Addiction Recovery & Resilience in Indiana (September 21, 2004)(citing National Alliance for the Mentally Ill Policy Research Institute, 2004; National Institute of Health, 1999).

29. Supra note 17.

30. Clifford, supra note 28 (citing National Council for Community Behavioral Healthcare, 2004 Candidate Briefing, as cited by the National Mental Health Advisory Council, Healthcare Reform for Americans with Serious Mental Illness in 1993).

31. Id. At the Dawn Project, a wrap-around program in Marion County, 70 percent of youth successfully meet their treatment goals and graduate from the program, with youth ages 8 or younger more likely to achieve success. The National Mental Health Association (NMHA) included the Dawn Project as one of 11 models nationally that have demonstrated promising results for effective intervention for youth with mental health needs in the juvenile justice system. See also, supra note 17, at 13.

32. See Appendix for complete list of Summit sponsors, participating organizations, and speakers; a current list of ISBA Civil Rights of Children Committee Members can be found at http://www.inbar.org/content/commitees/standing/CROC/CROC roster.asp

33. Christine Siegfried, Checking Up on Juvenile Justice Facilities, National Mental Health Association, September 1999.

34. Thomas Grisso and Richard Barnum, Massachusetts Youth Screening Instrument: Version 2 (MAYSI-2) (2000). For overview of implementation of MAYSI-2 in Pennsylvania juvenile detention centers, see Lourdes Rosado, staff attorney, Juvenile Law Center, Philadelphia, PA, Presentation for the Children, Mental Health and the Law Summit: Screening and Assessment of Youth in the Juvenile Justice System, Indianapolis, IN (August 27, 2004) (available at http://www.inbar.org/content/news/article.asp?art=340). The effort in Pennsylvania resulted after juvenile detention center administrators in 1999 identified mental health as their most important concern; they chose the MAYSI-2 as the screening tool that best fit their needs and resources.

35. Clifford, supra note 28.

36. 42 C.F.R. § 436.1004(a).

37. See Wasserman, Jensen, Ko, Cocozza, Trupin, Angold, Cauffman and Grisso, Mental Health Assessments in Juvenile Justice: Report on the Consensus Conference, J. Am. Acad. Child Adolesc. Psychiatry, 42:7, at 5 (July, 2003).

38. Individuals with Disabilities Education Act (IDEA) 20 U.S.C. § 1401; 34 C.F.R. § 300 et seq. (2004); Indiana Administrative Code 511 I.A.C. 7-17.

39. Office of the Surgeon General, U.S. Public Health Service, Mental Health: A Report of the Surgeon General (1999).

40. Tammy Seltzer and Ellen Harris, The Role of Specialty Mental Health Courts in Meeting the Needs of Juvenile Offenders, Bazelon Center for Mental Health Law, Washington, D.C., 2004 (citing James M. Kauffman, Characteristics of Emotional and Behavioral Disorders of Children and Youth (7th ed.) (Prentice-Hall, 2001)).

41. 20 U.S.C. § 1400(c).

42. Id.

43. Bazelon Center for Mental Health Law, Teaming Up: Using the IDEA and Medicaid to Secure Comprehensive Mental Health Services for Children and Youth, 8-13, August 2003.

44. Id.

45. 42 U.S.C. § 1396(r)(5).

46. See generally, Teaming Up: Using the IDEA and Medicaid to Secure Comprehensive Mental Health Services for Children and Youth.

47. For a publication discussing how to organize systems of care, see Shelia A. Pires, Building Systems of Care: A Primer, the Human Services Collaborative for the Georgetown University National Technical Assistance Center for Children's Mental Health, 2002. See also Chris Koyanagi, et al., Mix and Match: Using Federal Programs to Support Interagency Systems of Care For Children with Mental Health Care Needs, Bazelon Center for Mental Health Law, Washington D.C., 2003 (lists core values and principles for a system of care for child and adolescent services developed by the Child and Adolescent Service System Program (CASSP)).

48. There are a variety of reader-friendly booklets on special education law and learning disabilities available through the Indiana Department of Education, Division of Special Education.

49. K. Dwyer, D. Osher and C. Warger, Violence and Youth: Psychology's Response, American Psychological Association, Washington, D.C., 1993; U.S. Department of Education, Early Warning, Timely Response: A Guide to Safe Schools, 1998; H.M. Walker, R.H. Horner, G. Sugai; M. Bullis, J.R. Sprague, D. Bricker and M.J. Kaufman, Integrated Approaches to Preventing Antisocial Behavior Patterns Among School-Age Children and Youth, Journal of Emotional and Behavioral Disorders, 4, 194-209, 1996. See also The Safe and Responsive Schools Project, www.indiana.edu/-safeschl.

50. Thomas Grisso and Lawrence Steinberg, The MacArthur Juvenile Adjudicative Competence Study, The MacArthur Foundation Research Network (summary of results and methods, and tables available at http://www.mac-adoldev-juvjustice.org/page25.html).

51. 808 N.E.2d 631 (Ind. 2004).

52. *Resneck v. State*, 499 N.E.2d 230, 235 (Ind. 1986) (citing *Mato v. State*, 429 N.E.2d 945, 964 (Ind. 1982)).

53. The Indiana Juvenile Law Commission recently approved a recommendation that legislation be drafted to provide procedures for the determination of juvenile competency to stand trial (when competency issues are raised), including the possible dispositional alternatives of juveniles found to be incompetent. It further recommended that the legislation should be informed by the work and recommendations of the Juvenile ICST (Incompetence to Stand Trial) Program, Indiana Division Mental Health and Addiction, Family and Social Services Administration (DMHA/FSSA); the "Children, Mental Health and the Law" Summit, Indiana State Bar Association; and models that have been successfully implemented in other states. The DMHA has been looking at legislation and practices used by other states in addressing the issue of juvenile competency. In particular, DMHA has compared statutes and practices from Virginia, Georgia, Texas and Florida.

54. *Dusky v. United States*, 362 U.S. 402 (1960).

55. *In re K.G.*, 808 N.E.2d 631, 635 (Ind. 2004).

56. See Bruce Kamradt, Funding Mental Health Services for Youth in the Juvenile Justice System: Challenges and Opportunities, National Center for Mental Health and Juvenile Justice Research and Program, December 2002. Some important federal and state funding sources include Medicaid (in particular, the Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Program); the Individuals with Disabilities Education Act (IDEA) (school systems provide special education services, such as counseling, substance abuse prevention and behavioral management, to children with disabilities); State Children's Health Insurance Program (SCHIP) (a partial funding source for lower-income families that do not qualify for Medicaid); and Title IV-E Waivers (a potential funding source to develop community-based treatment services to reduce correctional placements). Other federal funding sources include family preservation program grants, Mental Health Block Grants (have been used in Indiana to help pay for screening and assessment for youth in the juvenile justice system), Temporary Assistance to Needy Families (TANF) (pays for services for low-income families and can be used to reduce out-of-home placements), OJJDP State Challenge and Formula Grants (awarded to states that are in compliance with the Juvenile Justice and Delinquency Prevention Act), and Juvenile Accountability Incentive Block Grants (the focus is primarily on law enforcement and juvenile courts). See also Chris Koyanagi et al., Mix and Match: Using Federal Programs to Support Interagency Systems of Care For Children with Mental Health Care Needs, Bazelon Center for Mental Health Law, Washington D.C., 2003.

57. See Jennifer Ryan, The Basics: Medicaid Financing, National Health Policy Forum, 2, September 2004 (available at http://www.nhpf.org/pdfs_basics/Basics-MedicaidFinancing.pdf)

58. Koyanagi, supra note 55, at 10.

59. Id., at 3.

60. Id. at 5-6. See also Virginia's Comprehensive Services Act. (§§ 2.2-4300-4377 (2001)) (allows innovative pooling of funds resulting in greater flexibility and inter-agency cooperation).

61. Supra note 36.

62. Supra note 45.

63. For a discussion on states' ineffective use of EPSDT to identify children who need mental health services, with recommended state policy changes, see Where to Turn-Confusion in Medicaid Policies on Screening Children for Mental Health Needs, Bazelon Center for Mental Health Law, Washington D.C., 2003. Also, for an initiative to launch juvenile diversion programs, see Rosado, supra note 34 (discussing the mental health-juvenile justice project in Pennsylvania led by the Juvenile Law Center with support from the MacArthur Foundation).

64. David E. Arredondo, et al., Juvenile Mental Health Court: Rationale and Protocols, Juv. & Fam. Ct. J. 1 Fall, 2001. Kurt Kumli, the supervising juvenile prosecutor in Santa Clara County, and one of the nation's leading advocates for juvenile mental health courts, provided the keynote address at the Children, Mental Health and the Law Summit.

65. Id.

66. 45 C.F.R. §§160 and 164 (2002). The HIPAA Privacy Rule establishes the federal floor for health information privacy protection. Under the law, protected health information is defined broadly to include past, present or future physical or mental health condition, as well as information related to the provision of services.

67. I.C. § 31-30-2-1; I.C. § 31-37-22-7.

APPENDIX

Acknowledgments

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Donald Murphy, Indiana Public Defender's Council

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Tom Rich, Evansville Psychiatric Children's Center

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