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# **Georgia** **at the Crossroads:**



**Children in the Juvenile Justice, Mental  
Health, and Substance Abuse Systems**

**2001 Rosalynn Carter Georgia Mental Health Forum**

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## **Surgeon General's Report**

*"Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by the very institutions and systems that were created to take care of them."*

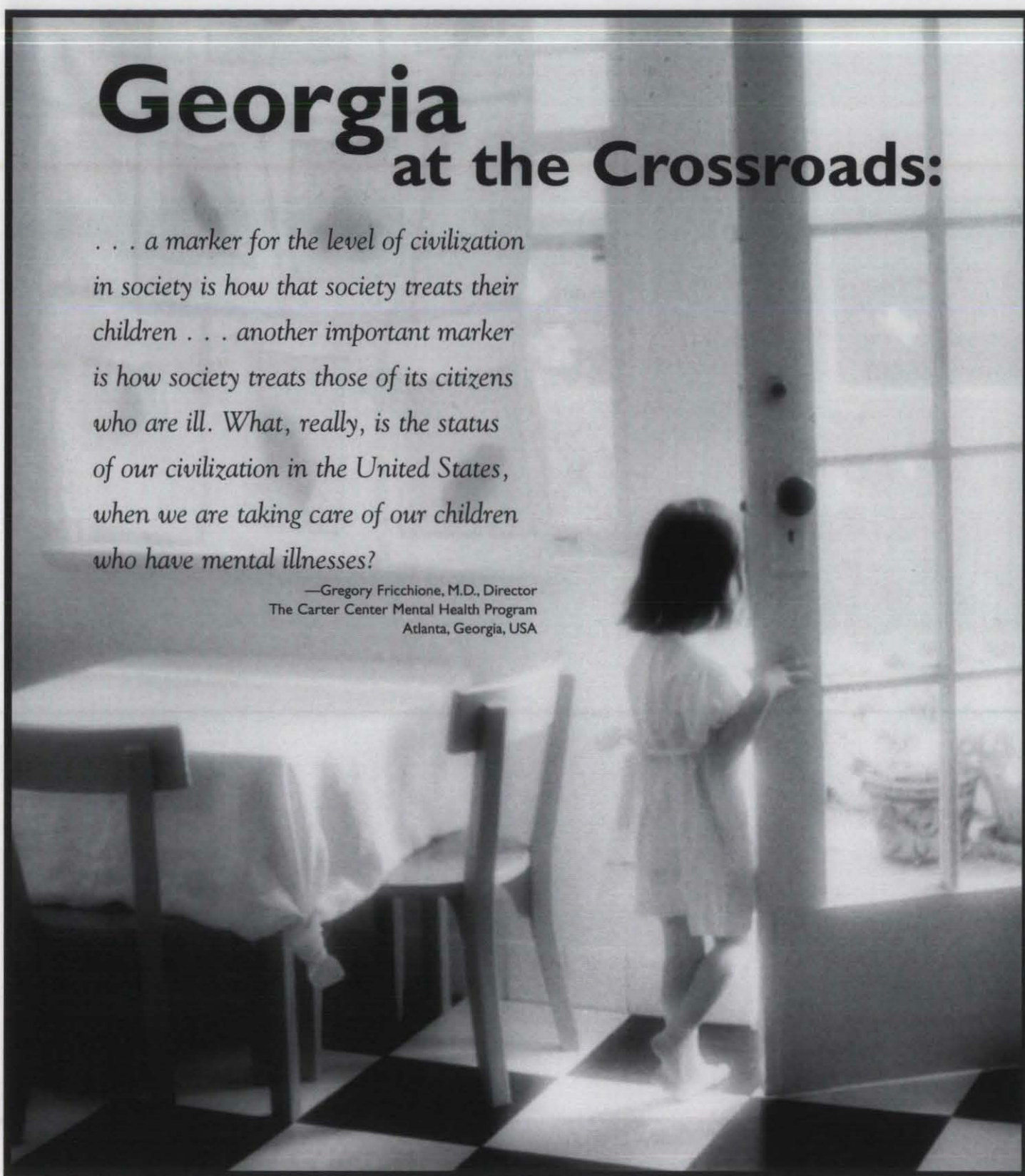
A National Action Agenda for Children's Mental Health,  
U.S. Surgeon General's Press Release, January 3, 2001



# Georgia at the Crossroads:

*. . . a marker for the level of civilization in society is how that society treats their children . . . another important marker is how society treats those of its citizens who are ill. What, really, is the status of our civilization in the United States, when we are taking care of our children who have mental illnesses?*

—Gregory Fricchione, M.D., Director  
The Carter Center Mental Health Program  
Atlanta, Georgia, USA



## **Children in the Juvenile Justice, Mental Health, and Substance Abuse Systems**

2001 Rosalynn Carter Georgia Mental Health Forum • May 17, 2001 • Atlanta, Georgia



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ROSALYNN CARTER, CHAIR  
THE CARTER CENTER MENTAL HEALTH TASK FORCE  
ATLANTA, GEORGIA, USA



*Social services for children, schools, recreation departments and the juvenile justice system all need to work together.*

**I**N 1998 THE U.S. JUSTICE DEPARTMENT investigated our Georgia Juvenile Justice System and the findings of that investigation were horrible. One area of special concern was the lack of mental health services for children diagnosed with mental illness. The investigation also looked at the children with mental illness who had never been properly diagnosed. Since that time, our state has been operating under a memorandum of understanding with the United States Justice Department to better meet the mental health needs of these children. Some good things have come out of this bad situation. More money has been invested to provide the mental health services needed, and programs have been developed to try to keep the children from getting into the system to begin with. But we still have a long way to go before we can say with confidence that our children are receiving adequate mental health and substance abuse services so they don't end up incarcerated.

In our mental health program at The Carter Center, we have focused on children's mental health issues on numerous occasions. We have looked at resilience and tried to understand resiliency—why some children can go through terrible upbringings and turn out to be well-adjusted young people when others cannot. We have collaborated with the schools in trying to recognize children with mental health needs and be sure they get care. We have focused on keeping children mentally healthy and advocating for early intervention. Children's and family issues are one of the priorities of our mental health program.

Now we need to look at ways to help the juvenile justice system. One of the best things we can do is bring together people who are responsible for the care of these children. We also need to get more people working together. Those responsible for social services for children, schools, recreation departments, and the juvenile justice system all need to work together so that our children receive the best care possible.



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# A Parent's Story:

## Georgia Parent Support Network

*MS. ZOGAA, A MOTHER OF FOUR, SPENT 10 YEARS AS A LICENSED PRACTICING NURSE FOR THE STATE OF MINNESOTA BEFORE RELOCATING TO ATLANTA. SHE IS ALSO A PROFESSIONAL WEST AFRICAN DANCER AND FORMERLY LED A DANCE TROUPE.*

I am a professional woman and have been most of my life. I lived in a nice home, drove a fancy car, came from a good family, and had lots of friends. In 1994, my life took a turn for the worse. That was when my mother and my sister were killed in a tragic car accident. All together, six members of my family were involved in the accident. The ones who did not perish were crippled for life. So I hope you understand that I am a broken woman at this time.

Shortly afterward, I moved to Atlanta, Georgia, hoping to start a new life for myself. I was not aware of the extent of the tragedy I had to face.

You want to know my story; the life of a mother who has a mentally ill son. Where should I start? Should I describe what it feels like to wake up in the middle of the night to find your child standing over you with a knife deciding if he should cut your throat or just torture you? Should I describe what it feels like being choked unconscious by your son, only to wake up hours later not knowing what happened during the time you passed out? Or would you like to know what it was like to be stabbed repeatedly by my child and all I could do was look at him and tell him, "Baby, I love you. I am here for you. What can I do to help you?" I do

not understand it. It is too much for me to understand.

There are some people, however, that I would like to thank. I would like to thank Dr. Gaffney, of the West Fulton Mental Health Institute, for coming to my rescue, without whom I would not have made it. I had given up on life, and wanted to commit suicide. I just did not care any more. I thank Jason Snow of Lower Heights. He really cared; He worked with my son, and made a big difference. Sonita Patel of the Southern Center, you just recently came into my life. Thank you Sonita. You made a big difference.

And of course my new family, Georgia Parent Support Network. That is my new adopted family. I thought the Juvenile Justice Center did not care at all and then I met a judge. His name is Judge Nash. As I looked up at you while you sat on your bench trying to decide the fate of my child, I saw mercy in your eyes and you gave my son another chance. Thank you from the bottom of my heart for being a real human being. I will never forget you.

Finally, Helen and Carl Ginsberg, thank you for listening to my story; I appreciate it.

There also have been a few who have not been very kind; I forgive you. The Department of Juvenile Justice, you said if I put my child in your care that you could do a better job than I could do. You see, I was lost at that time. I have no family and no friends; I have no one. So I trusted you. Your answer to my problem was to place my child in a

detention center where you left him for six months. You overdosed him with drugs and put him back into the general detention population. I came to visit my child, only to find his nose broken and knocked clean over to the other side of his face. You did not even seek medical care for my child; I had to demand medical help for him. Shame on you. But I forgive you.

Just yesterday I received a call from your department. You have had my son for almost three, going on four, years. Yet, he is not better, he is worse. But you decided to bring my child to my home, without my knowledge, and place him on my doorstep because you had nowhere else to put him. That is okay; I forgive you for that, too.

Just remember, I am not a bad person. Please do not judge me. You see, I have four children. I have a 26-year-old daughter with a degree in education. She teaches in a public school in Minnesota. I have a 23-year-old daughter who works in early childhood development. She loves children. I have more than 43 nieces and nephews. We all love each other. Thank you for listening to my story.







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# A Vision for the Future

*KEYNOTE SPEAKER: ORLANDO L. MARTINEZ, COMMISSIONER; GEORGIA DEPARTMENT OF JUVENILE JUSTICE; COMMISSIONER MARTINEZ IS A 30-YEAR VETERAN OF PROGRAMS THAT SERVE YOUTH AND THEIR FAMILIES. BEFORE HIS PRESENT APPOINTMENT, HE SPENT 17 YEARS AS DIRECTOR OF THE COLORADO DIVISION OF YOUTH SERVICES.*

**W**e need to rethink this issue of juvenile justice and how we treat children with problems like Ms. Zogaa's son. There is no apology that could be given that would ever replace what she has gone through, but it is heartfelt. It just means that we must work harder to improve the way we deal with children in our country and in our state.

The Department of Juvenile Justice has many challenges. We are

under a memorandum of agreement that adjudicates us by saying, "Look, you have to do better for children. You must classify them better. You must provide better health care services, including mental health. You must provide better programs for training staff. You must provide better educational programs. And you must use better sense in using restraints and confinement."

We are working very hard but it is an uphill battle. It is difficult to change directions in such a quick fashion.

We have begun, as a department, to look at ourselves more critically. We have a lot of challenges still facing us, but our strengths are very much evident.

One strength is that we are very clear that one mission of the Department of Juvenile Justice is to

improve public safety. Every one of us wants to be safe, and we want to continue to improve in that particular area. We want to hold people accountable, including children that are in our care, as well as our own staff.

**M**ore importantly, we need to start concentrating on developing better competencies, or skill building for our kids; give them better opportunities to live outside of our facilities and be able to live crime free. We believe that children need to have structure. They need to have accountability, and more importantly they need to have relationships.

Stop to think how difficult it is to develop relationships with children while you have them confined in some of our antiquated and poorly

## Rosalynn Carter:

**Q** What kind of staff would you have to help care for young people with mental illnesses? Do you have a psychiatrist, psychologist, and so forth on the staff?

Actually, over the last two years we have been able to improve staffing in the area of mental health treatment. We do have psychiatrists on contract at every one of our facilities. We do have psychologists that are on staff and also on contract. We have bachelor's level mental health workers that are in our facilities as caseworkers. So I think we have improved a great deal as far as staffing and having services available. We also

are contracting for services. We will be signing a contract with a private provider who will be providing 130 beds for kids who have special needs who are substance abuse/mental health needs kids. It is in mid-Georgia.

We also have a contract with consultants who have been working with us on developing an assessment and an orientation system whereby we can assess kids more properly as they come into our system.

We also have been able to work with the Division of Mental Health, Mental Retardation and Substance Abuse, the regional boards, and the community service boards, and we have projects at 16 different sites that have helped. So not only are we providing some staff

internally, but also we have been able to access staff through contracts in community settings.

## Rosalynn Carter:

**Q** One of the Rosalynn Carter Fellows for Mental Health Journalism wrote about mental health care for mentally ill people in prisons and jails. Prisons are the largest mental health institutions in the country. We all know that. He wrote about prison systems that contracted doctors who often times could not find a job anywhere else. They



designed facilities. One of our strengths, as we see it, is our sense of urgency. This sense of urgency is created by stories like Ms. Zogaa's; they remind us that we need to repair our system as quickly as possible.

We also are willing to try new things. We have become more of a learning organization. We are committed to studying and then practicing, rather than practicing and then studying.

The Department of Juvenile Justice has been waiting for permission to do the right thing. It is very clear that the staff who have been here for a number of years are really responding to that challenge and willing to do that.

We now face multiple public perception and public policy challenges. One is the "medical model" of thinking. That is, if you commit a child to the Department of Juvenile Justice—put him in this institution—then, just as in a hospital, when they leave that broken arm will be fixed. That does not happen with us. It is not possible for systems like ours to function in that medical model treatment method. What we need to think about are continuums. That is both a public perception and a policy challenge.

On the other hand, we are so fearful of children that we have "adultified" the juvenile justice system in Georgia. We have created a mini-adult system. You are old enough to do the crime; you are old enough to do the time. We have forgotten the special needs that children have during these formative years.

**F**or now, we want to talk about one specific challenge: Because of poor or little community resources for children, we have become the mental health

**were the lowest paid that the state could find because they did not have much money to hire mental health professionals. He spotlighted one particular company with whom many states had contracted and that had a particularly bad reputation. We checked on Georgia to be sure that the Department of Corrections did not contract with that particular company for mental health services for adults. Do you contract with the same service providers as the Department of Corrections?**

No, we are very cognizant of that situation. Let me give you a bit of our philosophy as far as contracting is concerned. In our department, we used to buy things that people wanted to sell us. That has changed. We are buying things that we need. Our needs assessments are done much better today. They are not perfect, but they are much better than they have been in the past. The second thing we did was to make it a competitive process. For a long time, Georgia purchased services on low bid. We were able to work with the Department of Administrative Services to include quality in the process. As a result, we have had to terminate some long-standing contracts that were being provided to the department.

We also feel that we want to do things efficiently and effectively. Efficiently means that we will have less recidivism. Effectively means that we will get the best bang for our dollar. That does not mean that it will be the less costly, but in the long term it will be a better investment. Mentally ill children are being treated in our facilities at a cost of a \$150 per day. When you think about it, if it were your child, you would pay \$150 per hour for a psychiatrist to

work with that child. So we need to start looking at investing in some of our population with those most severe needs up into the range of \$300 a day, at least. That is what we are struggling with. It is a balancing act. But by and large, I think our contracted services are beginning to improve.

**Q Could you discuss the training of the mental health workers in the juvenile justice system?**

Let me just speak generally of training. We recently developed a curriculum for training all the staff in our system and we are talking less surveillance and more on the relationship side. As far as training of mental health workers, I am not sure what we do.

**Q For Letha Zogaa: Is your son home with you now?**

No. My son is not home with me. My son really has not been home. He's been away about three years. He has been in the custody of the juvenile justice department now for two years and it has just been a cycle. My son is a runaway. When he is home, he runs away. So it has just been a cycle. They sent him home because they know he runs away, so I have been told. The thinking goes something like: "Well, we will send him home. We know he is going to run away. When he runs away, we can have him locked up." For two years that has been the solution.

### **Commissioner Martinez:**

Not to defend the department, but let me explain some of the complications when you handle kids with these kinds of needs and assist them in a juvenile correctional system. One is, his commitment may have expired. As we have changed the system and made it more adult looking, it basically says



that you have a certain time of commitment. At the end of that commitment, we have no legal authority over this youth. His treatment needs may continue, but our legal authority has ended. We cannot expend any money on any kid that is not under our legal custody. We also could get sued for intervening with someone who is not under commitment to us. It gets to be very complicated.

**Q Do you transfer juveniles to the mental health system if they leave when their commitment is up?**

That is up to the courts to transfer kids out of our system.

**Q Could you notify the mental health system that somebody is leaving who still needs help?**

Yes, and it usually is a pretty good discussion. We end up trying to find out who should spend the money. Ideally the money should follow the kid. The kid should have a blank check on his or her back and that should guide the services. But that is not how it happens. We get funded for certain kinds of functions under certain kinds of legal statutes, as does the Division of Mental Health or DHR. Something we think might be helpful in this area is that we have become eligible to earn Title IV-E monies as of

February 2001. The Department of Juvenile Justice was not accessing those dollars. Title IV-E dollars allow us much more flexibility for kids. Under the Social Security Act, kids who meet a certain economic criteria are eligible to receive these funds to facilitate their placement in the least restrictive alternative. So the monies fit with our philosophy that a kid should be treated in the least restrictive setting possible. If a kid needs to be at home with services, these funds could be made available for them if they are in our custody. They also could be placed in residential treatment centers or day treatment centers. They could be placed in a variety of less restrictive settings. These funds cannot be used for secure lockup. They cannot be used in detention centers or in youth development centers. We have targeted, for this next year, about \$9 million in this area to help us move in that direction.

**Q This is a question for Letha. How could the system meet you and your family's needs better than they have been met in the past?**

Well, I really do not know. I guess it would have been helpful, or it still would be helpful, if all the parties involved could just work together. This agency is blaming that agency and this one is saying that the other one is not doing its

job; and no, we should not be helping, this one should be helping. I mean, if we could just come together and work together. I am not asking anyone to raise my child for me. I just need help. I do not know where to go. Help me help my child.

**Q Commissioner Martinez, could you speak to efforts among state agencies to address these challenges to work collaboratively?**

Yes, and I will try and be a little bit more specific. One of the first things we tried to do two years ago was to look at ways to begin some joint planning with other systems. We discovered the Gwinnett Regional Board. Working with them, we were able to craft the Adolescent Achievement Program. There was trust on both sides and we were able to sit down and we were not guarding turf. We asked ourselves, "What can we do? How can we join together? And how can we share the monies for this?" There was a willingness to go out there and venture it. It is not a perfect system. There are a lot of flaws in it. But at least it began that process and the results from our studies of that project have been very good. So good, in fact, that it extended out to fifteen other regional boards. That is probably the Cadillac of our cooperative efforts right now. We

system by default, and that is a huge challenge for the Department of Juvenile Justice. Do we want to treat kids with mental health needs in a juvenile correctional setting? We need to answer that question. A more appropriate question might be: what types of children do we want to treat in the juvenile correctional system? That is a challenge for us and we hope that this forum is a beginning for us to be able to

answer that question.

Juvenile justice systems were never designed to handle the complex needs of kids with severe mental health problems. We have difficulty just dealing with situational or episodic mental health problems in our systems. Incarceration is not the place for the mentally ill child. It is going to take more than just one agency to improve the system. We are not the answer. We need

resources in other areas as well as our own. The reality is that children with severe mental illnesses are coming into our system, and it is not just in Georgia. My colleagues throughout the country indicate the same impact on their systems—more and more they are recognizing the significant mental health needs of the populations being committed to juvenile justice systems. The Surgeon General has



*Correctional mental health care, particularly among juveniles, is a national public health problem. The magnitude of mental health needs far exceed current resources.*

also recognized this. According to the Surgeon General's report published January 3, 2001:

"Correctional mental health care, particularly among juveniles, is a national public health problem. The magnitude of mental health needs far exceed current resources . . . Too often, children who are identified as having mental health problems and who do not receive services end up in jail."

This is true for adults as well as children today.

"Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by the very institutions and systems that were created to take care of them. These institutions and systems that, heretofore have been providing mental health services, have regressed. We see little effort to begin to increase their capacities to deal with this growing need."

As far as Georgia is concerned, let me bring it closer to home, and to what our kids look like when they come into our system. We have done a study in our department and found that 67 percent of those kids entering our facilities are on psychotropic medications. Sixty-seven percent have a documented history of involvement with outpatient community mental health treatment, and 32 percent have a history

of psychiatric hospitalization. What does that tell you? It tells me, that we are receiving, on the front-end, kids who have not been able to be treated by those systems in the communities charged with doing so.

Additionally, we find that 30 percent have a documented history of physical, emotional, or sexual abuse. That particular number is questionable because the figures for the survey were self-reported. I suspect that it is probably higher for boys, and I know it is higher for girls. While they were with us, 9 percent were placed in psychiatric hospitals.

In other words, they deteriorated

sufficiently within our systems to be placed in a psychiatric hospital. Twenty-two percent have made at least one suicidal attempt while in confinement. We also know that kids who are placed in detention centers are more likely to attempt suicide than those who are not in detention facilities.

We entered the year before last with the terrible realization that we were over expending the medications line item in our budget. Last fiscal year, we expended \$1.1 million on medications. Eighty percent of that expenditure was for psychotropic medications, which gives you an idea of the way we are administering medications, and the needs that our kids have. For example, 49 percent of girls entering our facilities are on medications. Fifty-seven percent of boys who enter our facilities are on medications. They come in with Ritalin and all the other kinds of medications that

are doing some efforts with education, trying to have them accept our kids, for example, when they come out of institutions. Public schools do not want our kids going back into their school systems because of school safety issues. As a result, they want to place them into alternative schools. Well, what do we do? Do we develop our own alternative schools or do we try to link in with them? That is an ongoing discussion that we have with the Department of Education. The issues with the Department of Family And Child Services (DFACS) are well known—we are often seen as the backup secure system to DFACS. If we cannot find a placement, then juveniles are placed in the detention centers. We are dealing with that and have crafted an excellent protocol with the Fulton

County Juvenile Court in resolving that kind of issue. It probably will be taken to other areas of the state.

**Q** What can we do now for Ms. Zogaa?

This is new to me. I never had to deal with anything like this before. I do not know what the answer is. I do not know what the solution is. All I ask is that you just help me. Lead me in the right direction. This is my child. I have the same hopes and dreams for him that others have for their children and I will not give up on him. I have been told to just leave him, lock him up and just forget I ever had him. Move out of town. This is my baby. I will never give up. I will die trying to save my son.



**Q Ms. Zogaa, does he have a case manager now?**

He has a probation officer through the Juvenile Justice Department.

**Q DeKalb County has established a mental health court for persons with mental illnesses who commit non-violent misdemeanor crimes. Are there any initiatives in place to develop a mental health court model for juveniles?**

No. The closest we have coming to that is a drug court in Dublin, Georgia. We are looking at establishing a drug court there for kids and being able to do something similar elsewhere. We have not been planning anything like a mental health court.

**Q When children are detained for a long period of time, how**

**should their mental health issues be handled, assuming DJJ feels it is not, and should not be, equipped to handle mentally ill children?**

We need to make the distinction between a juvenile detention center, or an RYDC [Regional Youth Detention Center], and a youth development center, which is a long-term treatment facility. Kids who are in juvenile detention are awaiting some sort of court action.

Many of those kids are there without having been adjudicated. In other words, they have not been found guilty of a delinquent act. We have no constitutional right to treat someone who has not been adjudicated of a crime. That responsibility lies with other systems that should be caring for that youth. Once a youth is committed to us, we then are responsible for providing all those services. We are beginning to improve in that particular area. But in the detention centers, that gets to be a problem. Now we see kids that need a

lot of mental health attention in detention centers, but again, the detention center is designed to ensure court appearance and for public safety. The detention centers are not even designed to provide for programming.

**Q What type of relationship does DJJ have with community mental health organizations to ensure children receive proper treatment once being released from custody?**

We are very poor at that. I was a federal court monitor in the state of Washington and we did a study, which I have sort of replicated informally here, that tried to take a look at how many kids who were in the mental health system prior to entering the correctional system were being followed by the community center while in our facilities. A surprisingly low number pops up. As far as transitional planning with community mental health systems, it is very poor.

have been prescribed for them. This is without any kind of research that I know of on the impacts these medications have on children.

We do very poor research on the effects medications have on any population, but specifically, on the impact of these medications on kids. What is the impact of combinations or portions of medications on these kids? I wonder sometimes if some of the aggression seen in our population might not possibly be related to some of the effects of these medications.

**M**ost of our kids, perhaps 90 percent or more, have some type of substance abuse problem. Even though they have these kinds of needs, our

systems have not been providing substance abuse treatment, as we should have been doing. So what are the solutions?

One is that the department and institutions can become more mental health professional in dealing with things. I am also concerned when a juvenile justice system becomes a mental health provider in such a fashion because it may draw more kids into the system. That is not to say that they should not receive the services; it is where they receive those services that is in question.

Another concern is why we do not just have the mental health system take care of all these needs for these kids. However, the history of funding for mental health has not

been good. The history of developing options in that system has not been good. That leaves only one other possible solution and that is the collaborative model. That is, maybe we should begin to work together on developing some solutions for this population. Maybe we ought to expand it beyond just mental health and the Department of Juvenile Justice. Maybe we ought to involve the schools. Maybe community systems ought to become involved in working with us and reaching a solution. Although that might be possible, it is very difficult to do. We all have our little turfs and we try to take care of those. But it is one option and one thing for the future that we must look at.



I also have a framework that ought to be used for this collaborative method. We need to do more individualized assessment and better case management of our kids. It also should happen early. As soon as a kid touches our system, we should be able to do a good assessment of that kid and provide better case management for that youth.

It can be done in any kind of community setting you can image. Community assessment centers have been used throughout the country to do this. Community assessment should involve mental health, the schools, and Department of Juvenile Justice, the courts, and all the actors in this kid's life. It also could be done in an institutional setting.

**A**nother necessary part of our framework is short-term, acute inpatient care. A lot of our kids do not need to be in acute inpatient care for long term. Many just need to be stabilized and then transitioned back into better settings. That should be developed not only in a secure institutional setting but also in a community setting.

We also need long-term acute inpatient care. I suspect the number of that type of beds in Georgia is not that great. We do have a 20-bed facility in Augusta that can serve some of that purpose, although we think that others should be developed outside of our facilities.

In terms of outpatient treatment, we need to get away from just monitoring kids and begin to provide them services. We then need to develop enhanced outpatient treatment for our kids. That means that we need to look at combinations of services for them.

That is a blueprint that we look at in the department and the direction in which we are heading to deal with mental health issues. We know we are an imperfect system.

We know we have much work to do. But I do believe that the Department of Juvenile Justice is ready to collaborate and ready to reach out and try new things.

## Back to Reality

CARL GINSBURG AND HELEN DEMERANVILLE;

2000-2001 ROSALYNN CARTER FELLOWS FOR MENTAL HEALTH JOURNALISM; FREELANCE VIDEO PRODUCERS, NEW YORK CITY. THE HUSBAND AND WIFE TEAM OF GINSBURG AND DEMERANVILLE HAVE REPORTED ON CHILDREN WITH EMOTIONAL DISORDERS WHO ARE CAUGHT IN JUVENILE JUSTICE SYSTEMS FOR NBC NEWS AND THE NATION MAGAZINE.

For three years my partner, Helen Demeranville, and I have explored the dilemma families face when a child with mental illness enters the juvenile justice system. In March we spent three weeks videotaping teenagers, parents, and officials in four states trying to understand better how sick kids end up in detention and how they are treated once inside. We were very disturbed by what we saw. Today we are presenting just a small portion of the work done here in Atlanta recently.

One thing that has struck us about all the cases we have studied thus far in Georgia and elsewhere is how similar they are, how young the kids are when trouble sets in, how confused parents are about what to do, how unwilling or unable schools are to effectively deal with mentally ill youngsters and how infractions of school rules and other status offenses set kids on the course to juvenile jails. Other common issues include the role of probation in keeping kids in the system and the smallness of crimes that lead them to lock up as well as the high rate of repeat detentions, the prevalence of self medication, particularly marijuana among this population, and the inadequacy of mental health services across the board.

It is a long, hard and often ineffectual road for mentally ill kids. "Tear me down to build me up," said one girl quoting a phrase invoked by her boot camp guards. With few exceptions, every mother we interviewed broke down on camera. They told us stories of children with mental health problems handcuffed at school and taken away, some as young as 6. Of officials who encourage them to file unruly petitions in order to get their children care, only to find out later that care takes the form of discipline, of detention facilities that resemble prisons, of kids angry and depressed upon release. The video you are about to see is meant to provide an impression of life for some of these mentally ill teenagers in Atlanta's juvenile detention facilities. We have accepted as fact what the kids have told us about their record and backgrounds. The facilities, DeKalb and Metro, are not dissimilar from other holding units we have visited.







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# Who Supports the Vision—

## Model Programs in Georgia Communities

*MODERATOR: SENATOR HORACENA TATE, (D-DISTRICT 38); ELECTED TO THE GEORGIA SENATE IN 1999, SENATOR TATE BEGAN WORKING IN STATE GOVERNMENT IN 1977 FOR THE DEPARTMENT OF LABOR. SHE PREVIOUSLY WORKED FOR GOVERNOR JIMMY CARTER.*

*WHITNEY FUCHS, EXECUTIVE DIRECTOR, GEORGIA COMMUNITY SUPPORT AND SOLUTIONS MR. FUCHS HAS BEEN SERVING GEORGIA NON-PROFIT ORGANIZATIONS FOR 17 YEARS. HE DIRECTS A STAFF OF 247 WORKING TO SUPPORT PEOPLE WHO HAVE DISABILITIES, MENTAL HEALTH NEEDS, AND SUBSTANCE ABUSE CHALLENGES.*

I would like to talk about why we are a part of this vision and what brings an organization that traditionally has served people with physical disabilities and mental retardation to supporting kids and adolescents in the community who have substance abuse problems and mental health needs. In August of 1999, my organization had just split off from a much larger one and we were going through a lot of growing pains, changing, and evolving. I got a call from the Executive Director for Gwinnett, Rockdale, Newton Regional Board. He said he had been talking with the Department of Juvenile Justice about some things that were not being done in our communities and he wanted to think more broadly. I asked what were the opportunities. What were things that could be done? He responded that he was

looking for a way to keep kids in the community who have substance abuse problems and are involved with the Department of Juvenile Justice, either through probate or through the YDC and RYDC systems from returning to the juvenile justice system. This included providing treatment and working with those kids in their communities to reduce recidivism. That was a pretty tall order, but I agreed to talk to my board of directors, which was all of three months old and hand picked from family members of people with mental retardation and other developmental disabilities.

I posed this question to them: We have been given this opportunity to consider. Number one, we do not have direct experience with this population of folks. We do not have a deep understanding of what their specific needs are. But we do have a value system. Our organization takes people with mental retardation who do not look like presentable employees to employers and say: "You know what? We see value in this person. They can be your employee. They can produce meaningful work and become a taxpayer of our society." We look beyond physical appearances and believe that people have value and they can make a difference in their own lives and in other people's lives.

We also realized that, at all levels, Georgia is a state of relationships. It is who you know, how you get along, who you trust. So my board said, "You know what? Let's go for it. Let's see what we can do." We

believed the whole concept of building relationships with individuals was a really important concept to transfer, even at the lowest level of this project. We also believed that this was about partnership. We did not have the experience to go it alone. We were brand new kids on the block. We had to go get a lot of information. We relied heavily on the people from the Department of Juvenile Justice to guide us and help us think about every little piece of this program. We realized that partnership was the only way this would work.

We also looked at some things about community. Community was so important. Community is what holds us together, what gives us a sense of who we are. It builds aspects of our personality. It supports us.

We also looked at family. One of our organizational values is we see families as valued components to any kind of support we offer. What we had to do was increase the confidence of the family and not tell them that they were doing the wrong job, but help them, guide them, work with them to build their own confidence. We believed in cross-pollination, acknowledging that we may not have this experience here, but we have a whole different set of values that can benefit these kids.

Through that we came up with the Adolescent Achievement Program. It started as a pilot in Gwinnett, Rockdale, and Newton Counties. We worked closely with



**Q** How can peers help students who are dealing with mental health and/or substance abuse problems?

**Whitney Fuchs:**

As far as substance abuse issues are concerned, peers are powerful, powerful actors. Think back to when you were younger and what influence as a teenager or a young adolescent your peer group had on you in terms of using alcohol and drugs. So to have successful treatment, we need to use those children to influence other children, just like we do in the adult populations. We usually find that peers want to be involved. Mental health issues are pretty much the same. Mental health issues that involve a lot of our children have to do with their behaviors. And their behaviors, of course, are what we see. But we need to work with them on how they think, how they make decisions. And their peers can guide them through that much easier than we can. One-on-one talk therapy is not effective for children 99.9 percent of the time. Children are effective in treating other children.

**Otis Lane:**

This is one reason we have the focus groups at the GIVE Center where for thirty minutes a day, rather than having individual counseling, they actually come together and share with each other and talk to each other and support each other. That is very important for students. It is also important that the leadership component is being instilled in them. A lot of these students have leadership abilities, but no one has given them an opportunity to do that.

With the YES Program—the Youth Leadership Academy—that is their main goal. When those students leave they go back to their regular schools and become leaders. How do they do that? We train them. We look at their talents. They work with elementary students. They have after school programs. Believe it or not, the youth leadership group went down to South Georgia when they had the tornadoes and helped deliver food and aid. So it is very important that youths mentor and support each other. With any initiative that you start, look at the leadership component. It is the peer-mentoring component that will allow youth to blossom.

**Bruce Thomas:**

One of our goals is if there are five kids, if we can help one, maybe that kid can help the other four. Kids hate the TRADE program when they first get it because it is so intense. But after completing the program, they are rewarded and have become productive young citizens in the community. Those kids then come back to work with the kids who are transitioned into the programs. I teach my older kids how to give groups some cognitive skills in case I am late or not there. These kids are articulate and can teach these groups just as well as I do.

**Debbie Law:**

At this point our program really works primarily with individual kids and their communities. So one of the challenges is identifying the peer groups that are not within the formal structures of education or treatment. And, frankly, we are struggling with some of those challenges. How do you break through to their peers in the community, their gang members in some cases? That is one of our challenges, to bring their local community, where they live, into their support network.

the Department of Juvenile Justice, Gwinnett County's local probation system, and with the Newton County Drug Court. We worked through a lot of problems that first year, telling ourselves that we wanted to look at the kids and what they were able to develop and the goals that they had. We also looked at other issues, including caseloads. We did not want to have a ratio of one to 85. If we were going to be successful at this we needed to think about access to those kids so that the folks who were out there in the communities would be very much a part of those children's

lives. So we have caseloads of one to twelve.

We also made the program community based. We do not put these people behind a desk. They go out there and meet with the kids on their turf—their homes, the families in their homes, their work, the schools, with probation officers. They have desks. They also have laptops, cell phones, and pagers. These people are part of the fabric of the community. We hire from the communities, if at all possible, so that we bring on board people with an understanding of the home community of that adolescent.

Last year, after our first year outcomes, we were told that the program was going to be expanded. That meant there would be different regions doing this, so we said we would like to replicate the program in DeKalb County and in Region Three, which is the northeast area of Georgia. The Executive Director of the regional board there liked this concept and asked us to do a pilot with kids with severe emotional disturbances. That started in December. We did one caseload because, again, what we are doing is transferring our values. We are looking at how we can impact



these children's lives. And we started working with the school system and the Department of Juvenile Justice. We are building bridges and, again, this is all community based. It is not run out of a center. These kids do not come to us. We go to them.

One of my values as an organizational leader is an understanding that it is the people underneath me that build the foundation for our organization. When I was looking for a manager to develop this program and to work as a team and a partnership, I was given a lot of opportunities to identify people who might have experience in this. And I chose someone who had energy, ambition, and the same value systems and understood the importance of building relationships and partnerships with the people they work with. This program manager, Ethan Elderidge, can describe the outcomes for that first year.

*ETHAN ELDERIDGE, PROGRAM MANAGER,  
ADOLESCENT ACHIEVEMENT PROGRAM,  
GEORGIA COMMUNITY SUPPORT AND  
SOLUTIONS*

During the first fiscal pilot period in Gwinnett, Rockdale, and Newton Counties we served 59 adolescents who were fully eligible for the program. There are a lot of different levels of eligibility, but the basic principle is based on adolescents who have been deemed at the highest risk of recidivism back to the Juvenile Justice System, and have identifiable mental health and/or substance abuse issues.

In that first year we had 100 percent of the program participants actively working toward or complet-

**Q** What is being done to bring the voices of the kids where policy is being set and programs are being developed?

### **Otis Lane:**

Students are an intricate part of planning for each of the model programs under the alternative school program. In fact, if you had an opportunity to visit the GIVE Center, you would think it was a regular middle or high school. They have student council, leadership groups, community service projects, and Awards Day.

In fact, I was their guest speaker. They have Awards Day every six weeks, rather than waiting until the end of the year. But our students are in and out of the program. All of these programs are transitional, by the way. They are not terminal programs. You are on your way somewhere. But we feel that student involvement is very important, even in our regular school program. If you do not involve students, then you become isolated in terms of their needs. You assume that they need this because we have provided this in the past, but the new generation provides new challenges for us. We have to do things differently. We have to work with parents differently. So it is very important that whatever program or initiatives we develop, regardless of what organization it is, you have to have room at the table for children to be part of the planning.

### **Deborah Law:**

Obviously all the great plans in the world are no good if the person you are planning for does not buy into them. The way we handle that in our organization is to ask the child what he or she wants. It is useless for us to develop a treatment plan for someone unless they want to participate in treatment. So we ask them what they want. We get

their opinion. We also have lots of programs that are involved in the various collaboratives where children have the opportunity to be peer counselors and peer leaders and to have input into what is going on in their home and in their neighborhood that bothers them. The one thing I have found is if we do not ask the people that we work with what their needs and wants are, we will never accomplish anything.

### **Bruce Thomas:**

The collaboration between mental health and juvenile justice develops a successful bond that puts the youth first. Everything else is put aside to work directly with the youths and the families and to keep the families involved. It cannot be emphasized enough how important it is to work directly with the families and the parents.

They play a major part because the only time we see the things that we see is during the home visits and when the kid comes in for counseling or other services. We work closely with the parents. It gives us the opportunity to know what is going on and the issues that need to be addressed after hours.

### **Whitney Fuchs:**

The design for this program is still fresh in my mind. One of the partners in the beginning included the actual people we were going to work with—the families and the kids. So they were a part of what the program was envisioned to be. And their input continues today. Each adolescent and their family sets an achievement plan for themselves, where they want to go from here. And that is the idea behind this. It is not about just meeting the criteria of your probate, but moving beyond that into what you want to do with your future and what steps need to be taken. And their participation is imperative, or the program is not going to work for them.



ing their community service assignments. We felt it was important to incorporate this into the program to both support judges' decisions within their courtrooms and show that adolescents were going to be accountable to decisions made by

the Juvenile Justice System. We also wanted to be able to advocate for directing some of these community service assignments so that they were valuable for the adolescent, giving them an opportunity to develop skills that relate to them

and opportunities to relate to their communities as they go on with their lives.

A second outcome was that 92 percent of these adolescents were participating in mental health or substance abuse treatment. It is imperative that we work together with both systems: the Department of Human Resources system, which provides services, and the Juvenile Justice System, which regulates and dictates that these adolescents participate in treatment. The crossover services between Human Resources and the Department of Juvenile Justice has been effective in transcending some of the turf issues, and identifying and advocating for appropriate treatment for these adolescents.

Another outcome of the Adolescents Achievement Program was that 100 percent of these adolescents were in school and/or employed. It is a mandatory part of this program that adolescents participate in school because they must have an education. If they withdraw from school they must receive their GED. Upon that, they go into the workforce. This program incorporates a multi-level approach beginning with simply filling out applications to actually advocating and working with local businesses to allow our adolescents to come in and to participate in real life interviews to gain the experience they will need in the future as they grow into adults and move into the workforce.

The last and most important outcome is that 81 percent of these adolescents did not commit new offenses. Of the remaining 19 percent, three had new drug charges, one was a theft charge, and the last seven were all status offenses. We

**Q What are your plans for the future of the Adolescent Achievement Program?**

**Whitney Fuchs:**

One of the remaining pieces we see is to build more community involvement from business professionals. Again, what we are looking at is trying to help these kids move out beyond their probate into where they want to go with their lives—to vision themselves at someplace rather than the here and now and just struggling to make it, but to where they see themselves growing. We actually are actively seeking funds to develop a mentor program to go along with this to get the business community where they live to be involved in their lives, show them what can be and what is possible. We think that bringing other interested parties into their lives can support them and also support the family.

**Q What percentage of kids from the alternative schools go back to the regular schools or go into the Juvenile Justice System?**

**Otis Lane:**

Students returning from the Juvenile Justice System used to come directly back to the regular school and we found that more than 50 percent of them were not successful coming from a program where they were under strict management. These students now

transition back through our GIVE Center. They are not on suspension. They are enstated until they are ready to go back. But what happens that is so important is that data collected by the Department of Juvenile Justice is received by somebody who actually sits down and reviews it, talks with the students, talks with the parents, asks them what their plans are, what are they going to do when they return to their regular school. Believe it or not, less than 15 percent of them have problems now when they return to their regular school.

I foresee the day when we can have another program because some of the students feel that they are being punished when passed through the alternative school to get back into a regular school. The local public school systems need to form a closer collaboration with the Department of Juvenile Justice because we are doing the same thing. We are in the same business. While students are there, they are being provided an education. When they are released the hope is that education continues. Our programs have potential. They are doing well now, but the potential if we all continue to work together is unlimited. We will have success. We will not be talking about 35 or 40 percent success, but will be saying: "Every youngster." We know where they are, what happened to them. You know, the 110,000 students we have, we love every one of them, but they get lost and nobody has paid attention to them. Our superintendent issued a challenge to every principal to find an adult to mentor every child at their school. I think that is a lofty goal.



are most pleased to bring that statistic to everyone today because it is traditionally rather high. We feel the reason for this achievement is the ability to build relationships; to sit and work with a family and break through the walls that adolescents have built up because they have been dealing with the system. They learn how to block out different people. They learn how to play the sides because they see the turf wars. They see what is going on and how different entities interact with each other and they get in the middle and learn how to manipulate this. The coordinators that work with these adolescents build the relationships with the families to support, advocate, and mediate for the families between all the different entities—employment, school, mental health, treatment for substance abuse—to try to collect all this information and have one lead person who can feed it to them and mediate among all these different entities.

There are a lot of challenges that the Adolescent Achievement Program faces including turf, being a new program, and the growth across the State of Georgia. But we are proud of our success in dealing with people as individuals, building relationships with families, and showing the value of these adolescents to their families and their communities. Linking every possible service in the community to the adolescent has brought a new sense of responsibility and accountability to the families, the juvenile justice system, DHR, and the communities they serve. It also facilitates and enables the communities to look at different approaches when working with their adolescents so they are not removed from their communi-

ties and placed in different detention facilities.

*BRUCE THOMAS, PROGRAM COORDINATOR/  
INTENSIVE AFTERCARE, DEPARTMENT OF  
JUVENILE JUSTICE/ ALBANY AREA  
COMMUNITY SERVICE BOARD MR. THOMAS  
DEVELOPED AND IMPLEMENTED THE  
TRADE PROGRAM. A U.S. ARMY VETERAN,  
HE HAS SERVED AS BOTH A CORRECTIONS  
AND LAW ENFORCEMENT OFFICER.*

The TRADE program, which stands for Transitional Reintegration And Decision Enhancement, is a collaborative program between the Department of Juvenile Justice and the Division of Mental Health located in Albany, Georgia. The program is an intensive aftercare program offering six to eight months intense transition working with the kid once he is released from the Department of Juvenile Justice placement. It includes short- and long-term group homes and a wilderness program.

We only work with kids who are committed to the Department of Juvenile Justice, which makes referrals within thirty to sixty days of release. At that time, we start the transitional process of reviewing any charts for mental health outpatients, reviewing the juvenile justice files, reviewing psychological evaluations, and conducting home visits to get the parents actively involved with the youth's transition back into the community. We need the support of the parents. They keep no secrets from us. We keep no secrets from them. They report the day-to-day activities of the kid. Once the home visit is completed, we do a site visit with the youth at whatever placement they have in the state. At that time we do a

social assessment using the Child Adjustment Rating Scale. We also conduct an in-depth interview with the youth at that time and interview the staff who actually have worked with the youth while in that placement.

Collecting all that information helps us complete a successful treatment plan for transition back into the community. The first day back in the community, a TRADE staff member is at the bus station, or wherever, to pick up the child, take him or her home, and conduct family counseling, verifying the treatment plan's goals, conditions of probation, and what is expected of him or her once back in the community. It is difficult to explain just how important it is to work hand-in-hand with the parents. Without their support, the program would not be nearly as successful.

Once the kid is back in the community, we conduct individual counseling, group counseling, and family counseling. We work with different agencies in the community that provide resource support and services. TRADE staff are on call 24 hours a day, seven days a week. That really helps keep down the referrals to juvenile court intakes because if a crisis occurs in the home, parents can page us and we will call them immediately and try to deal with the situation before it gets out of hand. The majority of the time, problems are resolved then. We provide the youth with cognitive skills, group counseling, life skills, peer pressure skills, problem solving, and anger management. The life skills and the problem solving training are important because they show them how not to re-offend and to look at the situation differently because every



**Q** Your program sounds like a very good program. How can one get his or her child into a program like yours or in your program, even though they may not live in your area?

**Bruce Thomas:**

Hopefully the Department of Juvenile Justice and the Division of Mental Health will allocate the programs statewide. I would be overjoyed to start a successful structure, since I originally started the program and got it off and running.

**Q** Where do you receive your funding and what is the cost per child for your services?

**Bruce Thomas:**

Well, the Department of Juvenile Justice pays 70 percent of my salary and the Division of Mental Health pays 29 percent, and we do not bill Medicaid. Initially the program was funded by a grant and at the end of the grant, the two departments sat down together and worked it out. If we can get more than that, more collaboration would be great. I cannot overemphasize how important this intensive aftercare program is. We

are going through some changes. It is not a program to deal with alternative placement. It is intensive aftercare to work with youths once they leave placement, to transition them back into the community.

**Q** As a Juvenile Court Judge, most of the children I deal with have dysfunctional families. I have questions as to how effectively troubled children can be dealt with in these homes. Do you have any thoughts on that?

**Whitney Fuchs:**

I would say that is one of the biggest challenges in working with kids. We have a set of values that we take with us when beginning the process of identifying the value in children and how we can build families' confidence and vision of their own children when they do not have that vision of themselves and their own competence in raising and supporting their family members. That is one of the biggest challenges faced by every system that works with kids. Is there a way around that? No. If you bypass the family in any capacity, you are looking at failure. I do not think that ignoring the problem

is the way. I think making referrals to mental health, family counseling, working on building their confidence as a family, is the way to go.

**Debbie Law:**

That is part of what we are trying to do, as well. Frequently we identify that something is going on with a child. This can be as obvious as the child's removal from his or her home for some period of time. Yet even if they are in regular treatment and returning home, that family has needs. The family has needs because the child has needs.

What TRUST tries to do is identify one person who will go into the home and hook that family. Hook the family personally into everything that they might need that we know can be provided. And may I add that it is not just state agencies that we are looking for. In South Georgia we call ourselves the land of five P's: peanuts, pine trees, poultry, produce, and poor folks. So what we try to do is hook into other areas that touch us, for example, the church community, which is so important to all of us and so willing to help in many, many areas. Also business and industry—they will provide funding and services. We try to hit them up for everything we can to help any family, whether it is get them a job, find them a home, or whatever.

problem can be resolved.

The program has had a number of successes. Most of the youths received their GEDs. Some youths have attended technical college. Others have attended college including the University of Illinois, Albany State University, Georgia Southwestern, and Dorman College. We also teach independent living skills and assist them in locating full- or part-time jobs. After completing the six to eight month

program, 90 percent of the kids live productive lives as young citizens in the community.

*OTIS LANE, PH.D., DIRECTOR OF STUDENT DISCIPLINE/BEHAVIOR INTERVENTION, GWINNETT COUNTY, GEORGIA IN ADDITION TO HIS CAREER AS A PROFESSIONAL EDUCATOR, DR. LANE IS A VOLUNTEER WITH BIG BROTHERS, THE RED CROSS, THE UNITED EBONY SOCIETY AND THE BOY SCOUTS OF AMERICA.*

**G**winnett County Public Schools is the largest school system in the State of Georgia with 110,560 students this year. We are expecting another 7,000 new students next year. We are ranked at the top of the state in all academic categories. Of those 110,560 students, we have approximately 400 in alternative education. They need more than just what can be provided to them in the regular classroom.



My position is unique in the school system. On one hand, I enforce board policies and procedures, and both federal and state laws with regard to student discipline. On the other hand, when we remove them from the classroom, or, in laymen's terms, when we kick them out of school, what do we do with them? I have the intervention component. That is an advantage for me because it has forced me to get out of the box and change my philosophy on managing students.

Discipline is very important. But by the same token, we cannot expect discipline alone to save this current generation of youngsters who are coming to us with an array of problems from the very first day of school.

In 1994, I realized that I had a great opportunity. Rather than occasionally meeting with other community leaders of private and some public service providers, I had an opportunity to really sit down with the Executive Director of the Gwinnett County Coalition and to lay before her a plan, a dream that I had with regard to discipline intervention for students in Gwinnett County Public Schools. And you know what? She acknowledged that, indeed, it was a dream, but she wondered if we could make it work. More specifically, could I make it work? My response was that I could not make this dream a reality without help.

Early on I involved other community leaders in having some input in alternative school programming. Before that time it was mainly an evening program for high school students, but I realized in 1994 that the problems we were having in high school were filtering down to middle school and, of

course, today they even reach elementary school, and we needed to get out of the box and do something different.

First we needed to have a day program. Students were at home with no supervision during the day. What are they going to do? Get into more trouble. So we decided to have a day program and we initially wrote a grant together. We received the grant to get the program started and the rest is history because from one agency to another, I went on the offensive. I did not stay in my little corner of the field and tell others to come to me. In my field, which is education, we really believe we can do everything for youngsters, and that simply is not true. We are very good at educating. And in all our programs we do that. But in terms of going out and working with families and providing mental health support, physical help, etc., we are not so good at that. We do not have time to do those things. Alternative education cannot be more of the same. I realized early on that we had to meet negative attitudes and behaviors with positive attitudes and support. Those are the two premises our alternative programs are built on.

The Gwinnett Intervention Education Center (GIVE) is our largest alternative program. This program is for youngsters who make mistakes, who are removed from their regular school for 18 weeks to one year. They go to a different site where their day is well managed. Only parents can pick them up, no friends. The highlight of the GIVE Center is that 75 percent of their day is academically driven. For the remaining 25 percent, they are in focus groups working on the kind of problems that got them in trou-

ble in the first place.

Sixty percent of the students at the GIVE Center are there because of drug abuse. Forty percent are there for disruptive behavior. We had to design a program to deal with that, so we developed services beyond the academics: recreational therapy, substance abuse education, drug and alcohol recovery groups, leadership development. Many of these youngsters have leadership abilities. We just have to tap into that and channel it into positive things that they can get involved in, including service learning, community service projects, and Project Adventure. We have kids involved in gangs. They need help, support, guidance, and counseling.

We have family outreach programs; a lot of the problems brought to school are family related. We have community leaders who visit the site weekly. We serve as an intern training site for counselors and social workers from the University of Georgia and Georgia State. The YMCA started a pilot program from 1:30 PM until 6 PM with a group for youth who do not have anything to do after school.

The GIVE Center is very successful. Less than 10 percent of the students who go through that program return. That is one of the key objectives of discipline: break the cycle. Cut down the rate of recidivism and your program will be very effective.

A second program is called the GRASP Program (Gwinnett Remediation and Support Program), an arm of the GIVE Center. We had students who were not successful in the GIVE program and, up until two years ago, we simply released them, let them go home with nothing to do. Now we feel



### **Rosalynn Carter:**

If we could replicate these programs across the state it would just change the whole outlook on how our children are treated and how they act. But I have a proposition for the public schools. In the mental health field we know that if children get a good start in life they have a much better chance of growing up to be well-adjusted young people. I have worked hard to get a bill passed through the Georgia legislature that would require children be registered for school at age 2. It passed last year, but it is voluntary. Children already are registered for school by age 4. But if they are required to register by 3 years of age one year and 2 the next, they would have to have all their immunizations. That is the only way I know to institutionalize immunizations for children—get them at age 2. But also we could screen them for any physical or mental health problems and identify them and take care of them when they are young.

that no matter where a student is, they are going to get an education. We can educate you wherever you are. We will find you and we will make sure that that key component—education—will continue.

The GRASP program focuses primarily on middle school youngsters. Instead of sending students home, they enter a program in which the day is reversed. They have 75 percent therapeutic intervention and 25 percent academics. We also bring in the heavy hitters—the mental health workers and the social workers. In fact, one of the teachers is a certified social worker. We bring in counselors and really focus on those behaviors that that child is not able to control. That

program has been very successful. Right now we have 21 students in that program who otherwise would be home or out on the streets.

The third program is called Project RESCUE (Restoring Educational Services to Children or Youth Under Suspension or Expulsion). This program is not housed on school property. These youth are placed in the program as directed through the Gwinnett County Board of Education through permanent expulsion, meaning that their behavior is so bad they cannot return to a regular school setting, or they are placed there by a court order from a juvenile court judge or by the Department of Juvenile Justice. This program is housed in the Department of Juvenile Justice on the square in Lawrenceville. These eight youngsters have a teacher and an aide who work with them. Some attend part time, others full time. Some cannot handle a full day even in that setting. They come in the afternoons or during the day. The success of that program is based on the students' knowledge that they probably are not ever going back to a regular school and therefore have to make a decision to either complete their studies with a GED—and we help them through the GED program—or enroll in some kind of technical or vocational education program. That program has been very successful for us.

The fourth program is unique and was started by a community of volunteers. It is called the YES program, or Youth Leadership Academy. What a name for youngsters who are on suspension out of school. This program is housed in a church. We went directly to the Gwinnett Ministerial Alliance and

told them we have volunteers who want to work with kids who are on suspension, especially middle school youngsters, whose parents are not even interested enough to make sure they go to the regular alternative school. So we went out in to the community, found quite a few of these students, and established that class. The volunteers who help there work full time. They get off half a day or a whole day during the week. They come to work with the teacher and with those students. We have been very successful with that program. We even have been able to get a couple of students back into a regular school program.

I have bigger dreams. Some of the problems we deal with go down to the level of kindergarten. We have youngsters who need mental health support the very first day they show up in school. Special education is not the answer. The federal guidelines are strict now—if a problem behavior is not emotionally based, we cannot place students in that program. Who can make that call at age 5, anyway, that a youngster should be placed in special education? So we have to come up with alternatives. I have a dream that involves bringing people together like social workers, psychologists, psychiatrists, special education teachers, regular education teachers, to form what I call a trauma intervention team that can go directly to the classroom and work with that student, teacher, and family to try to intervene at the earliest age because the earlier the intervention, the better results you are going to get.

Yes, we are having a high degree of success with the middle and high school youth, but can you imagine the results if we worked with the



first three grades? In our school system, we said every child must be able to read by third grade. I will follow that up with every child should know how to behave by that time.

*DEBBIE LAW, CHILDREN AND ADOLESCENTS SERVICES COORDINATOR, GEORGIA PINES COMMUNITY MSMRSA SERVICES MRS. LAW HAS SPENT THE PAST 25 YEARS WORKING IN THE GEORGIA DEPARTMENT OF CORRECTIONS, THE STATE BOARD OF PARDONS AND PAROLES AND AS A TEACHING IN BOTH PUBLIC AND PRIVATE SCHOOLS.*

We started a program that builds on the TRADE program, that I was lucky enough to know something about and be involved in. We moved a step forward and took it to TRUST. Most programs get children who already have been identified by the school system, by their parents, or by the mental health system. They have been involved with the Department of Family and Children's Services and frequently they have been involved with all of these agencies prior to ever being in Department of Juvenile Justice custody for any reason.

So what is wrong with that picture? If we are all touching these children's lives, why aren't we making a difference? We decided to take a look at why we are not making a difference. Part of it has been the old agency turf protection that is talked about. When I first came to Georgia Pines as the Child and Adolescent Coordinator, one of the problems that I heard a lot was, "Mental health is not doing their part," or "This is a mental health kid." Well, this is a child, not a mental health child. This is a child, not a DJJ

child. So what is wrong with this picture is that mental health possibly was not doing their part because we were not saying, "What can we do for your agency? Where can we plug in? Where is the gap? What do we need to do to make a difference?"

We often hear in the state that there is not enough money or there are not enough resources, and, of course, we all operate under budgets. But it is really interesting when we sit down at a table with one child and all of the stakeholders—whether it is the probation officer, the caseworker for DJJ, the school-teacher, or the mental health counselor—what we can accomplish and how much money we can locate from each agency that will follow that child, that will be available to provide services. That is what the TRUST program does.

It really is not a program. It is a person. It is a person who has the ability to call upon the agencies and get people together at the table to provide the services. We do not go through a long eligibility process. If we get a phone call to help a child, the first question is not going to be does this child have mental health problems? The first question is going to be what kind of help do you need? And once we start doing that with one another, we discover that there are many wonderful programs available.

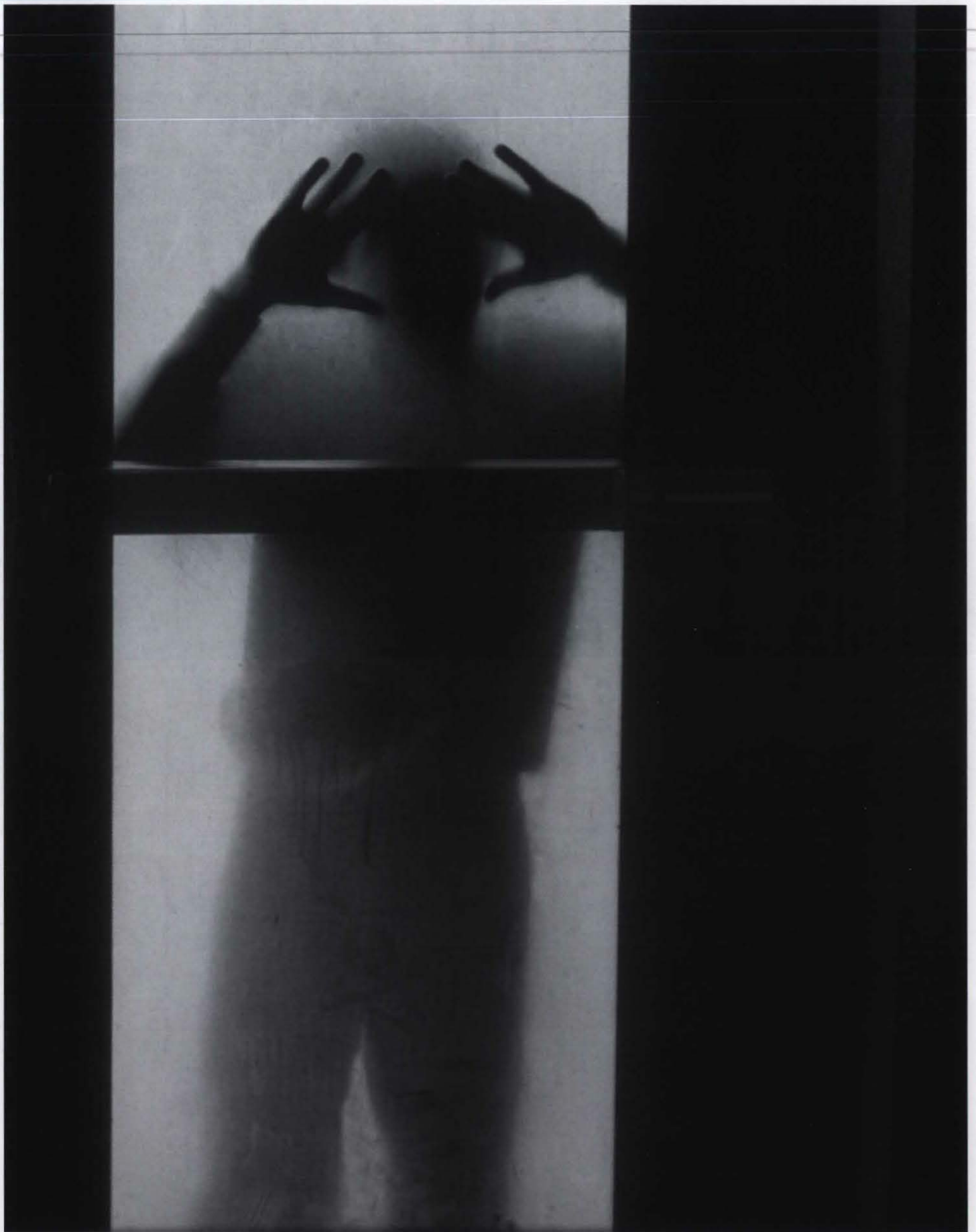
We have a child who was in DJJ custody, was in a RYDC. He has been adjudicated twice for different events in his life. He is 14 years old. The child was adopted so the Department of Adoptions was still involved with him as he and his adopted family began to have problems. He has been adopted for about eleven years. And with all the problems that he has experi-

enced in his life, his adopted parents are almost ready to give up. They have tried to work their way through all of our systems unsuccessfully because they have not had one consistent contact person.

The Department of Family and Children's Services is involved in his case for various reasons and he has a caseworker from them. He had a mental health caseworker because he had received day treatment from them. There are two private agencies involved with him. So here we have the best help offered in the state, but we were not getting anywhere.

We had a meeting through our TRUST person where we all sat together at the table. We were able to find little pots of money to use for all types of resources for this child. We have been able to place him in a group home where he is receiving treatment. He is happy. He is making progress learning to control himself and even knows the mental health buzz words. All of us came together and now everybody is relieved. We know that he is going to be in this residential treatment facility. He is still involved in all of our services. Nobody handed him off from one to the other. His family is involved in our services and we are going to keep contact. We are making plans for him for two years from now. If we are unwilling to make a change in his life by doing that, then we need to rethink the whole system. Positive cooperation, collaboration, person to person, will make a difference.







# How Far Away is the Vision— Mental Health Services for Youth in Custody

*MODERATOR: REPRESENTATIVE MARY HODGES SQUIRES, (D-DISTRICT 738)*  
MS. SQUIRES BEGAN HER POLITICAL CAREER IN GEORGIA IN 1982 AND HAS BEEN A LOBBYIST FOR THE PHYSICAL THERAPY ASSOCIATION OF GEORGIA. SHE ALSO SERVED IN THE ARMY NATIONAL GUARD, ATTAINING THE RANK OF CAPTAIN.

*JIM DEGROOT, PH.D., MHMR DIRECTOR, GEORGIA DEPARTMENT OF CORRECTIONS (GDC) DR. DEGROOT HAS BEEN A FACULTY MEMBER OF BOTH THE LETTERMAN AND EISENHOWER ARMY MEDICAL CENTERS AND HAS PROVIDED CONSULTING SERVICES FOR THE GDC AND THE JOBS CORPS.*

Let us start off by looking at two trends. The first: between 1987 and 1997, the number of juveniles incarcerated as adults has more than doubled nationally, jumping from 3,400 to 7,400. Now what about Georgia? Did Georgia follow suit? Not really. The number of juveniles incarcerated as adults in Georgia at any one time has never exceeded 60. In fact, the number of juveniles incarcerated under the age of 17 has never exceeded 30.

The second: during the past five years, the rate of incarceration of the mentally ill in the United States and Georgia has increased two to three times. In Georgia, between 1995-2000, the rate of growth of the mentally ill population grew three times faster than the rate of growth of the non-mentally ill population. Another way of looking at it is to talk about the percentage of

**Q Are needs assessments done on youth before they are discharged from the juvenile justice program?**

Needs assessments are done. We do a placement, risk, and needs assessment on youth who are committed to our agency. It is part of the treatment planning process, so any time there is a significant change in a youth's status with our agency—and change from one placement to another would represent that—there is a needs assessment done that guides the treatment plan.

**Q Are they referred to other agencies or monitored in any way?**

Yes. They are monitored as a part of the treatment planning process and we do, as common practice, refer to other agencies.

**Q Many important issues and problems have been brought up today by this panel and others. What is the next step? Will these groups work together or just go back to business as usual?**

I think that is a decision for all of us. I think generally change does not happen spontaneously. Change happens when sometimes a very small group of

people decide to make a difference. I mean, if out of this group there are five of us who make a commitment to do something about it, I am sure we will do something about it. If there are two of us who want to do something about it, we can do something about it. If there is one of us who wants to do something about it, we can do something about it. But I think the beauty here is that there is such a broad representation of institutions, professionals, practitioners, parents, consumers. Why not think through how to use today as a moment when we light the candle to start a path to try to help these kids? These kids need help. I am here not so much to tell you the statistics. I am here not so much to tell you the department is doing a good or bad job. I am here to tell you these kids need help and each one of us can do something about it and if we think of a strategy to organize all of the energies in this group and the energy of people who we are connected with, I think we can make a difference.

The time seems to be right for agencies working together. A number of us have gotten together from the Department of Human Resources, from the Department of Juvenile Justice, from probation, parole and from corrections. Looking at this population we are serving, the mentally ill and mentally retarded population, many of us are serving the same population. They come into one of our systems. They leave. They go out into another system. So now we

the inmate population receiving mental health services. Back in 1995, 8 percent of the total inmate population was receiving mental

health services. This past December it jumped to 13 percent. It has grown consistently by 1 percent per year for the last five years.



are trying to develop ways of tracking who is receiving what resources and trying to provide a better continuity of care.

**Q** One of the main drivers for some of the things that have happened—for instance, the children who have been placed in the Department of Corrections as opposed to the Department of Juvenile Justices—is that politicians have voted for legislation that has done that. And we, there are some of us, Horacena, myself and others, who work with these agencies to make sure that they work together. We work with them to undo some of the harm that has been done. What, if any, prevention programs are available through DJJ?

Of course, when we received the mission of prevention, it was an unfunded mandate. So it really depends on what you define as prevention. We see every program that we have as being hopefully preventive in nature in that we keep children from going further and further and further into the system. The programs, our arms of prevention, are really through the Children and Youth Coordinating Council where they have become administratively attached to us this year. They provide local communities funds to do locally-based community programs. They look to us for guidance to say: "Yes, this is consistent with the mission and with the goals and with the vision of our agency." But they, in fact, administer those funds to the local communities through the governor's Children and Youth Coordinating Council.

Nationally, the National Institute of Corrections (NIC) did a study a year and a half ago and their results show that 16 percent of the inmate population—state inmates—receives mental health services. If you look at it by gender, 11 percent of all male inmates receive mental health services, and 34 percent of all female inmates receive mental health services. In summary, we can say that we are incarcerating more juveniles and people diagnosed with a mental illness than ever before.

Before talking about juveniles, I would like to share some demographic data on our inmate population.

- 70 percent have less than a high school education.
- 40 percent have less than a sixth-grade reading level.
- 62 percent have less than sixth-grade math skills.
- 23 percent of our inmate population is married, so 77 percent are either single, divorced, separated, or widowed.
- 95 percent of our inmate population have at least one child. There are a lot of children out there right now whose parents are incarcerated.
- Georgia's unemployment rate is somewhere between 3 and 4 percent. Inmates, the year before they were incarcerated, were unemployed at a rate of 41 percent.

Looking at juveniles in the Georgia Department of Corrections, currently we have a little more than 4,000 inmates under the age of 21. That makes up about 9 percent of our total inmate population. The number of inmates under the age of 21 has increased over the past 10

years. Eleven years ago, in 1990, it was 6 percent of the total inmate population, now it is 9 percent. So we are incarcerating more youths.

In Georgia we consider 17-year-olds adults. They can come into our system. What about those under 17? That number has not increased. It has stayed pretty constant. At any point in time it is somewhere between 20 and 30 people.

How many juveniles do we have in the prison system now? Currently we have 52 who are placed there, sentenced under Georgia's Juvenile Justice Reform Act. This is a relatively small number. These 52 are all males. At the present time we do not have any females under 17. We have had. I know of two females who entered our system through this reform act. Fifty-two juveniles make up approximately one-tenth of one percent of the total inmate population, which is approximately 45,000. The point is that the juvenile population in the Georgia Department of Corrections is very small. Obviously very important, but very small.

Georgia's Juvenile Justice Reform Act was passed in 1994. We were concerned that we were going to be overwhelmed, that the flood gates were going to open up and we were going to be overwhelmed with juveniles. So we began to write policies and procedures. We began to debate the need for an official program. Did we need to set up a separate juvenile division within corrections? We were waiting month after month and we were in the process of writing these policies and procedures, but the juveniles never came. Instead, they trickled in and leveled off between 20 and 30. The count never got larger than that.

Now what do juveniles have to



do to be convicted under the Juvenile Justice Reform Act? There are seven offenses: aggravated child molestation, aggravated sodomy, rape, aggravated battery, murder, involuntary manslaughter, and armed robbery with a firearm. If a juvenile is charged with one of these, does he or she have to be tried as an adult and sentenced as an adult? The law is ambiguous here. I am not a lawyer, but I talked with two lawyers yesterday trying to figure this out. It sounds like they are supposed to, but at the same time they leave a lot of discretion up to the judge. Obviously that is why we have not been overwhelmed with juveniles coming into our system. A lot of judges are not, for one reason or another, trying them as adults.

Is there a bottom limit to the age when a juvenile can be tried and sentenced as an adult? The answer is yes. The age is 13. The youngest juvenile we have ever had—we have had two—was 14. Let me tell you, they really looked out of place. First of all, both these kids were small. And to see them in a uniform behind bars was quite a sight.

Let's look at the ages of juvenile inmates.

- There are no juvenile inmates who are 14.
- There are four who are 15.
- There are 12 who are 16.
- There are 36 who are 17.

Another factor to consider is the race of juvenile inmates.

- The white population is 11, or 21 percent.
- The non-white population is 41, or 79 percent.

How does this compare to the adult inmate population? The adult population for many years has been 33 percent white and 67 percent non-white.

*One of the main drivers for some of the things that have happened—for instance, the children who have been placed in the Department of Corrections as opposed to the Department of Juvenile Justice—is that politicians have voted for legislation that has done that. And we, there are some of us, Horacena, myself and others, who work with these agencies to make sure that they work together. We work with them to undo some of the harm that has been done.*

Looking at historical data:

- Fifteen, or 29 percent, exhibit criminal behavior
- Twenty-four, or 46 percent, report substance abuse.
- Thirty-two, or 62 percent, have an absent parent. About two thirds of them come from single-parent or truly fragmented homes.

Looking at the offenses these 52 juveniles have been convicted of:

- Murder—10, or 19 percent.
- Voluntary manslaughter—three, or 6 percent.
- Armed robbery—36, or 69 percent.
- Sexual offense—three, or 6 percent.

Looking at length of sentence:

- One has a nine-year sentence.
- Twenty-three have 10- to 12-year sentences.
- Eleven have 13- to 15-year sentences.
- Four have 16- to 20-year sentences.

- Three have sentences of 21 years or more.
- Ten have life sentences.

Three of those with life sentences are 16. One of these 16-year-olds has two consecutive life sentences. Does this youth understand his sentence? He does not have any idea what that means, and people have tried to explain it to him. But he does not grasp what this sentence is.

What does this Juvenile Justice Reform Act say about mentally ill juveniles? In essence what it says is that mentally ill juveniles are not to be tried and sentenced as adults. In other words, if it is determined pre-trial that they have a mental health diagnosis then they go into juvenile justice's domain. Do we have mentally ill juveniles in prison? The answer is yes. Obviously they are diagnosed after they come into our system or they develop emotional problems after they come into the system. How many do we have? We



**Q** What role does DJJ assume in working with DFACS, youth and staff, that is, in regard to prevention efforts, runaways, disruptive placements to help these youth stay out of YDC and prisons? DFACS seems to be left out of this picture. Why?

We currently have what we consider to be a major initiative going on with the Department of Family and Children's Services. Before, children were found in detention centers and no one seemed to know who put them there, who released them, who was responsible for them, what the plan was. The commissioners—acting Commissioner Redding, Commissioner Martinez—took that issue and have signed a cooperative agreement between the two agencies where by every county in Georgia will have a formalized agreement that says specifically at the point that a child is referred to the juvenile court that we

will work with the court. We will have an agreement that identifies specifically who is responsible for what so that no child will fall through the cracks. There will never be a point in time when there is a child in a detention center of whom the case managers are not aware.

So that is our major initiative right now with Department of Family and Children's Services. That may not sound significant to anyone else, but when you start getting two agencies and the juvenile courts to come together and to agree on these things and see the agreement between the two commissioners signed about 60 days ago, that is significant. They gave us 60 days to come up with the agreement in Fulton County. We finished that. It goes to them next week and then by the end of this fiscal year, not the current one, it will take a year to get all the counties completed, we should have a formalized agreement in every county of the state. So we are very enthusiastic about that.

have 12 juveniles out of the 52, or 23 percent, who are diagnosed with a mental health problem. These 12 are receiving mental health services. They are, of course, all males. That is about 25 percent of the juvenile males we have. How does that compare to the adult population? If you recall, 11 percent of all adult males are receiving mental health services. With juveniles it is about a quarter. And this quarter, supposedly, did not have mental health problems prior to coming into our system.

All 12 of these juveniles have a mood disorder. They have some sort of depressive disorder. Quite a few have adjustment disorder with depressed mood or depressive disorder not otherwise specified. They

are receiving mental health services. Everyone who comes into our system, adult or juvenile, is given a mental health screening by a mental health nurse or a master's degree counselor within 24 hours of coming into the system. If there is any question of mental illness, they receive a comprehensive mental health evaluation from a master's degree counselor.

Next, they meet with a psychiatrist or a psychologist who at that time determines if they need mental health services. If they do need mental health services, they are assigned a mental health counselor whose responsibility it is to develop a treatment plan. The treatment plan is developed in collaboration with the juvenile or adult and with

the treatment team. The treatment team is made up of psychiatrists, psychologists, mental health nurses, activity therapists, and correctional officers. Currently we have 21 state prison mental health treatment teams. In other words, we have 21 programs in 21 state prisons. Juveniles are sent to only one prison so there is only one treatment team that develops treatment plans for juveniles. When the treatment plan is being developed it is determined what level of services or level of care the juvenile or adult needs. In other words, can they live with the general population and receive mental health services as an outpatient? Can these juveniles live with these other 52 juveniles and do well, or are they at risk for being victimized? If supportive living units are needed they are provided. If acuity is high they are given acute care or are placed in a crisis stabilization unit.

Treatment services are constantly reviewed and include: individual therapy from a psychiatrist or psychologist if needed; group treatment; psychotropic medication if needed; and activity therapy. School, including special education, and some work is done with families on a case-by-case basis.

Treatment services will include discharge planning, but we have not released any mentally ill juveniles. This act was passed in 1994 and we did not start receiving juveniles until late in 1995. Most of their sentences are longer than four or five years. When we do release them, they are going to fall under the transitional aftercare program. This is a relatively new collaborative program including the Department of Human Resources, the Board of Pardons & Paroles,



and the Department of Juvenile Justice. It provides a case manager to start working with the juvenile hopefully a month before they are to be released. The manager finds out what the needs are and provides wraparound services for this individual upon release. Preliminary data is impressive. It shows that recidivism has dropped for individuals who receive this case management wrap-around service.

*GWENDOLYN SKINNER, EDS, NCSP, LMFT, DEPUTY COMMISSIONER, DIVISION OF COMMUNITY CORRECTIONS, GEORGIA DEPARTMENT OF JUVENILE JUSTICE ON STAFF WITH THE GDJJ SINCE 1978, MRS. SKINNER'S SCOPE OF MANAGEMENT INCLUDES SERVICES FOR 23,000 YOUTH ON A DAILY BASIS.*

I would like to begin with the case of George Stinney. Charged with the murder of an 11-year-old white female, executed at the age of 14, three months from the time of his arrest. The newspaper read:

"Here is what happened to George Stinney in Clarinden County, South Carolina, on June 16, 1944. At the age of 14, weighing 95 pounds and standing five feet and one inch, he was lashed into an electric chair and a mask was put over his face. He was then given a hit of 2,400 volts. The mask, which

was too big for him, thereupon slipped off. The witnesses saw his wide opened and weeping eyes, his dribbling mouth, before another two jolts ended the business and fried him for good."

In Virginia, the year 1990, a 14-year-old girl and her boyfriend murdered her parents. He got the death penalty. She was sentenced until age 21. In Baxley, Georgia, the year 1992, a 12-year-old youth was charged with murdering a 4-year-old by hitting him on the head with a liquor bottle, cutting the child with broken glass, and then burying him alive. This youth was given a two-year sentence and placed in a psychiatric treatment facility. He now resides in Florida with his mother. In September, 1999, in Cherokee County, Georgia, 15-year-old Jonathon Miller was given a life sentence for hitting another youth on the back of the head as they got off a school bus. The blow caused a microscopic hole in the artery at the base of the youth's skull that resulted in his death two days later.

These cases represent the tremendous amount of variance in sentencing practices within the

juvenile justice system. Fourteen-year-old George Stinney was arrested, tried, convicted, and executed in a matter of only three months. A 1944 setting in the south, black on white crime—the arrest and conviction of this child was the accumulation of decisions beginning at the point of arrest, as well as a lack of consideration of factors such as neglect, deprivation, and emotional and intellectual functioning.

Some things have not changed very much. More often than not, the disposition of the youth's case is more significantly impacted by factors such as demands of the victim, who the family is, color of skin, and the need to satisfy the community at large rather than the assessment, evaluation, and treatment needs of the youth. In fact, recent research confirms this. A 1996 study examined the factors that various court workers perceived to affect juvenile court dispositions. They work in the courts every day, so they were asked: "What do you think influences the dispositions?" They ranked offense and delinquent history first and second. They ranked treatment needs third. In ranking the factors that were actually considered, treatment needs dropped to sixth place, preceded by offense, delinquent history, family functioning, school behavior, and age. A subsequent study was conducted last year and it examined the court's utilization of mental health reports in disposing of cases and found that even when mental health reports were available, the courts were much more likely to consider home conditions when making dispositional decisions.

In preparation for this presentation, I was reminiscing about the 23 years I have spent in Georgia's juve-





nile correction system and am sorry to say that the treatment for juvenile offenders really has not withstood the times nor the politics that we have experienced. That is to say, the services are influenced or driven by the tenor of the times. In the 1970s, we institutionalized status offenders. We created crisis intervention counselors. We developed community treatment centers and emergency shelters. We relied very heavily on family therapy. The 1980s brought residential community-based treatment centers as well as assessment and classification and screening. The 90s, in contrast, saw the proliferation of boot camps and a model of justice that embraced punishment under the guise of accountability.

Understanding that a significant percentage of youth involved in juvenile justice have mental health treatment needs, we are now moving from a retribution model to a restorative model, emphasizing victim awareness, treatment, preparation for the community, and competency skills. The vision, and there is a thin line between vision and hallucination, is that every youth entering the juvenile justice system in Georgia will be properly evaluated and that the needed treatment services will be available, regardless of where they live or regardless of the availability of funds.

The Department of Juvenile Justice is reorganizing. We are regionalizing our services so that the lines of service delivery will be consistent with those of DHR. Partnerships and collaborations with parents, local communities, other government agencies, community groups, and private citizens will create the opportunities and conditions necessary for juvenile

offenders to mature into healthy, self-sufficient adults. We believe very strongly that the family is the single most powerful influence in a child's life and plays a critical part in their treatment process. We want to extend treatment to families to enable them to support and contribute to their child's improvement. Future planning for services in Georgia will be driven by the profile of youth in the local community, but guided by the department. We anticipate a reduction in duplication of services and services that are more responsive to the local communities' needs for their children.

When you talk about juvenile corrections, you must remember that we are part of the executive branch of the government. We provide services to the youth that we receive. We do not identify the children that come into our system. We are given the population that we serve.

If we work in child serving agencies because we believe that children are different than adults, then why are we locking up so many children and why are we treating them like adults? If we believe that children are our most valuable resource, then why are we locking them up? If we believe, and we do believe in the Department of Juvenile Justice, that secure confinement should be limited to dangerous or violent offenders, then why are we locking up seriously emotionally disturbed children and calling it rehabilitation? Do we endorse zero tolerance in the school system? Do we endorse zero tolerance in general? In the name of public safety, do we justify locking children up and sorting them out later?

It is the contention of the Department of Juvenile Justice that justice is best served when the community, victim, and offender receive equitable attention and all gain measurable benefits from their interaction with our system.

*TONY FERNANDEZ, CONSULTANT, GEORGIA DEPARTMENT OF JUVENILE JUSTICE*  
*MR. FERNANDEZ HAS 20 YEARS EXPERIENCE IN MANAGING AND DEVELOPING MENTAL HEALTH AND HEALTH CARE SERVICES IN FLORIDA, PUERTO RICO, THE DOMINICAN REPUBLIC, NEW JERSEY, AND GEORGIA.*

As Commissioner Martinez pointed out, the issue of mental health needs of children and youth in the juvenile justice system is a national phenomenon. He underscored several statements that were made in the U.S. Surgeon General's report earlier this year. The important thing to discuss is what is really so unique, specific, important, significant about the Georgia response and the Georgia opportunity to handle this national crisis? In the last year and a half I have been impressed by the bold approach, by the open, sincere, soul-searching, critical, reflective, introspective approach that this department, under the leadership of Commissioner Martinez, has taken to tackling the hard issues—to asking the hard questions, formulating critical challenging viewpoints on how it is conducting its mental health services.

I remember when Dr. Ron Koon, Director of Mental Health Services, and I met for the first time to go on a grand tour of the state. His first disclosure to me was: "Tony, I want to take you where it hurts the most.



I want to take you to the sore point of the system. I am going to take you to the places where we are really having problems." And indeed, all we had to do was open the door and the problems were there. We did not have to dig deep to see the suffering, to see the anguish, to see the despondency, the dejection, the utter frustration on the part of these kids seeking services. Many times we saw the heroic efforts of a very committed group of staff to try to address rather significant problems within a context that has not been designed to address these problems within a delivery system that, as Commissioner Martinez said, has become a mental health delivery system by default, not by design.

The first important aspect of the department's commitment and the unique approach that it has taken in addressing this issue is to look at the population. It took guts to go out there and let us see who we are dealing with. For a period of several months, the department contracted and commissioned external psychologists, psychiatrists, and mental health professionals to provide an objective external evaluation of the population that was coming into the system, both male and female. The results, some of which were shared with you by Commissioner Martinez, were not so surprising. Sixty-seven percent of the kids came in with extensive mental health histories.

Interestingly, the same number, 67 percent, had substantial substance abuse problems. Forty-five percent had joint mental health and substance abuse problems. What is being referred to now as ADM problems: alcohol, drug, and mental health problems.

Digging deeper, we have been

studying the population of the girls that are coming into our long-term programs. Of the young girls who have ADM, in our long-term programs, 80 percent have faced sexual and many times sexual and physical abuse, often of a persistent, chronic, cruel nature for many years. Only 10 percent of the boys in our committed population have a family where both parents are present. Forty-one percent come from single mother families and many of our kids have documented, demonstrated suicidal tendencies by history.

Who are these kids? Are these kids court criminals? Are these kids violent offenders? The majority of them are not. And at least 69 percent are being arrested and are being committed on what is known as Part Two Offenses, non-violent offenses. We are arresting and we are committing "innocent" victims of cruelty and of social and psychological deprivation. Thirty-nine percent of the kids who are coming into the system have no family support to go back to and that is probably an understatement. Eighty-three percent of those who penetrate the depths of our commitment of our long-term programs have had prior experience with the juvenile justice system. They often are recurrent admissions to many of our facilities and have participated in other systems including mental health systems in the community as well as alternative programs, and have failed.

So what are the realities? The realities are that we are dealing with youth who have multiple problems, complex problems. We have larger numbers of youth than we were ever set to handle. The severity of the problems appear to be increasing. The services are

### Gwen Skinner:

**Q** The problems that have been talked about are all mental health problems. Why is mental health not participating more fully in resolving this problem and what can be done to get mental health at the state level to be a more cooperative partner in this effort?

I cannot answer why they are not currently involved in this. What it will take to get them involved, I believe, is going to have to come from the commissioner level down, and I also believe that our judges have to be very actively involved. They have to require, and I feel very strongly about this, they must require the agencies to work together. It is very tiring to hear that cases go into court and that our staff, all of our staffs, look at the judge and say: "We do not have anything." I want the judges to say to them: "You have a certain amount of time. Come back with something," and hold us accountable. And we need the judges to help us with that. That is where the judges are very much a catalyst for change, causing the agencies to work together.

insufficient to meet the demand and about 21 percent of the kids that we surveyed in the system receive mental health services at the YDCs, the long-term programs. Thirty-five to 40 percent in the Regional Youth Detention Centers receive mental health services. But the truth of the matter is the staffing, as committed and as extensive as it may be, is not enough to handle the demand.

There is a further problem. We have a conceptual problem. The programs have been designed like silos. We have designed programs



with artificial categorical distinctions often driven by funding categories, federal, state, local; often driven by departmental boundaries; often driven by bureaucratic fabrications that have nothing to do with the complex reality of problems that our kids confront. I am reminded of the childhood story of Humpty Dumpty. We have looked at our broken kids and taken the approach of trying to fix one of the pieces. But who is trying to put Humpty Dumpty back together again?

What is the challenge? The challenge is building integrated delivery systems. The challenge is designing programs that address the complexity of the population. The challenge is establishing a comprehensive and flexible continuum of care that extends to and from the community.

We have a model for a treatment/service continuum. We have been preaching this model for a while. Many components of that model are in place. But the integration of the model—the ability to have it work with the youth at the center of the model, with the flexibility to move kids according to needs and to try to promote placement in the least restrictive alternative—is not there. That is where the greatest challenge lies for all of us.

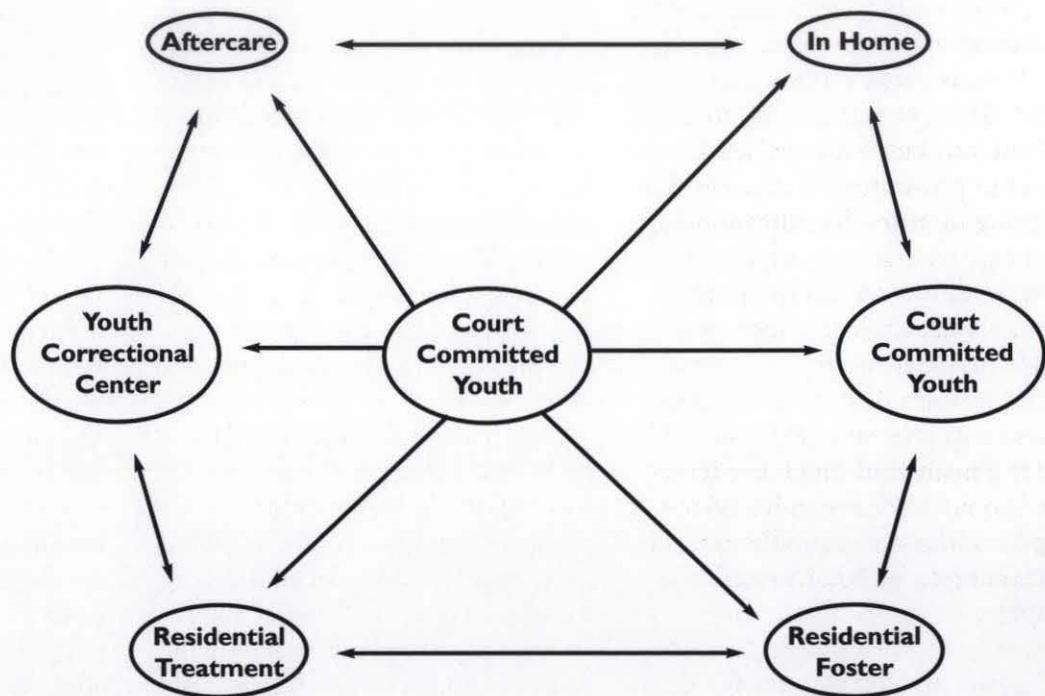
So what are the implications of everything that we are faced with? First, we need to rethink our policy assumptions, our program and funding framework. We need to challenge the notion and the practice that we con-

tinue to fund mental health programs and programs for the mentally retarded and programs for substance abusers when our kids, many times, face all these problems simultaneously. We need to start putting Humpty Dumpty back together again, and we have the opportunity to begin doing it here in Georgia. That can be a significant contribution to the field. That can be important from a national policy program development perspective.

We need to establish holistic, youth-centered, needs-centered approaches and focus on the care that we give our kids. We need to emphasize, early screening, comprehensive assessment, and differential diagnosis. We cannot apply the standards of adult psychiatry, or even some of the traditional standards of child and adolescent psychiatry, to juvenile mental health needs and to the juvenile mentally ill population we are dealing with in this system. Multi-disciplinary approaches and multi-interventional approaches are needed.

Abraham Maslow used to say: "When the only tool you have in life is a hammer, you tend to treat everything as if it were a nail." If the only tools we have in our system are psychiatrists and psychotropic drugs, guess what is the prevailing mode of treatment in our system? Psychotropic drugs. Is it because the kids need psychotropic drugs or is it because we do not have anything better, more creative, more ingenious to provide these kids? Is it an issue of treatment or is it an issue of chemical restraints?

These are the hard questions. These are the issues that need to be addressed if we are going to make a difference. We need to conduct research. The Carter Center and some of the academic institutions in the State of Georgia are doing advanced work. Let us join together. Let us be bold to participate in multi-centric studies to understand the nature of the comorbidity and polymorbidity of our population. Let us evaluate what we are doing.





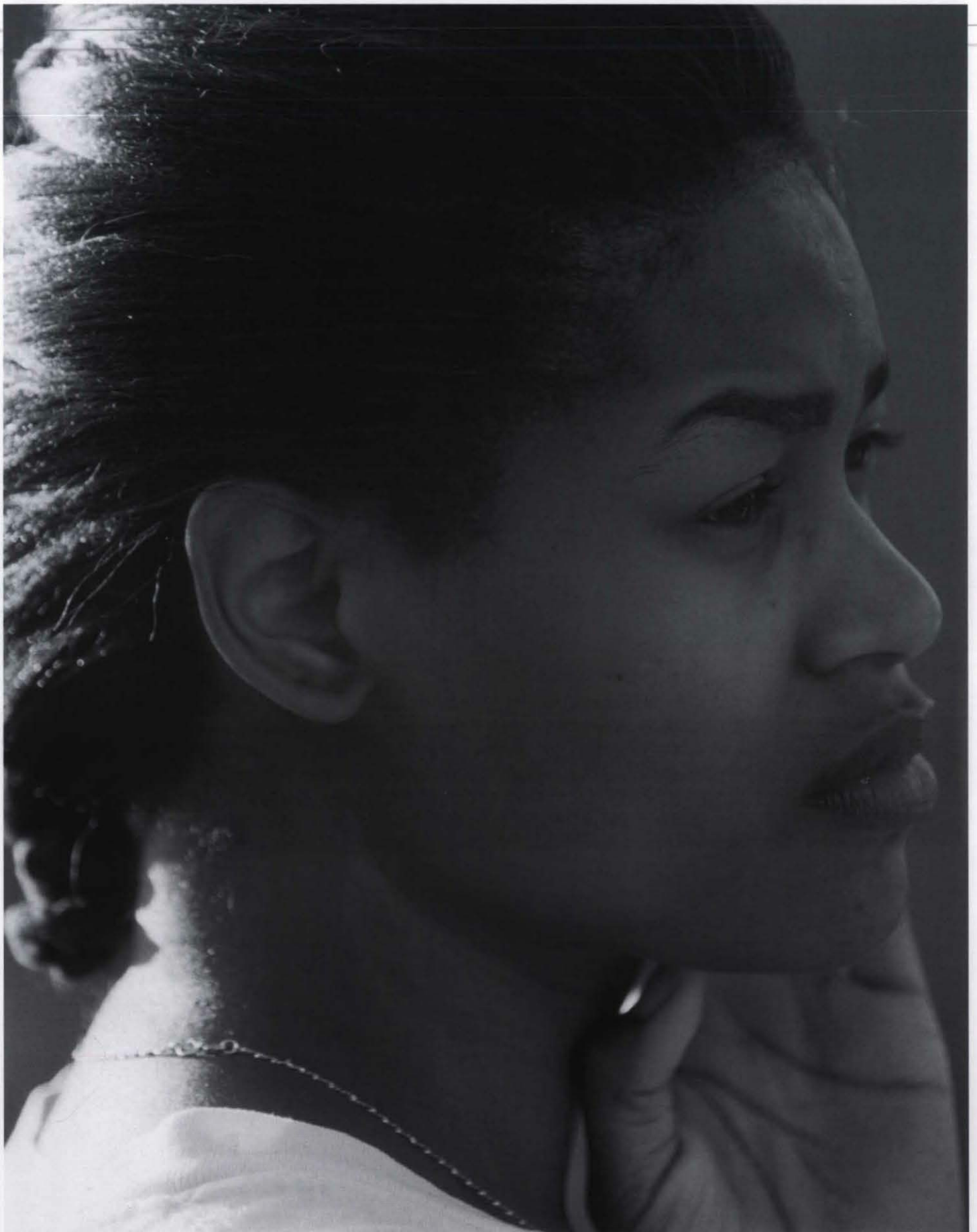
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Let us find out whether the approaches that we are taking make a difference. Let us analyze the outcomes and not be afraid to find out that this does not work, because at least we know we can scratch that from the approach.

Let us look at quality. Often times we feel in the public sector that quality is not an attainable objective or goal. It is a hallucination more than a vision. Let us commit to quality and let us commit to best practices. There are many good programs that are going on. Let us identify those programs. Let us help develop them, formulate them, standardize them, and then practice it and learn from practice and learn from experience. Let us take advantage of this opportunity to convene our thinking, to seek communion of effort instead of those things that separate us. Let us look at those things that unite us—concern for the kids—and let us decide that we can work together to advocate, to lead for change for the kids, not to protect my department or my agency or to get this contract. Let us talk about what can we do together for the kids because these kids are silent. They do not have advocates.

And last, but not least, let us invest in prevention, a concept that we bring from the healthcare field, a concept that is one of the more exciting things happening in the mental health field. Let us invest in prevention. Prevention in juvenile justice means different things than it means in the mental health field and the healthcare field, but let us talk about it. What can we do to stop kids who are mentally ill from continuing to be incarcerated unjustly?







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# Surviving to Thriving— Helping Children Successfully Navigate Systems of Care

*KRISTINE MEDEA, M.A.A.B.S., DIRECTOR,  
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When we speak about what is best for children, we talk among our professional selves, losing contact with the voice that we are charged with helping to find a place in the world. We need to be reminded of why we are here.

Over the last decade, the extended debate about children and mental disorders has dominated the community. The issue continues to be polarized with one end of the continuum being that all disorders are genetically and biologically based. On the other end of the spectrum, returning to the Bad Mother Syndrome, it is the parents' fault. Clearly, it cannot be all or nothing. But in the larger context of our society, we must address the impact of social justice issues such as poverty, racism, and violence. And yes, we also know that there is often a genetic vulnerability activated by external stress and trauma.

It has been tempting to pathologize the child and avoid messy exploration of the context of his or her life as it relates to presenting symptoms. In the attempt to treat children in a medical model of care,

we have become overly focused on fixing the child by controlling symptomology and behavior. We have neglected to concurrently address the glaring impoverished, emotional, and psychiatric experiences of many of these children. In this polar system of care there seems to be only two explanations afforded these youth who are identified as behaviorally challenged. They are either sick, bad, or both. In our attempt to reduce the stigma and discrimination many parents experience when they have a child who presents behavioral challenges, we now only focus on fixing the sick kid. We have omitted the need to work with these families in a systemic manner and now look for more holistic answers to healing.

The absence of skepticism about the inherent benevolence of treatment and the assumption that help cannot harm must be challenged. If we are to move forward in a system of care that facilitates long-term healing for those families and children whom we seek to serve, my belief is that to successfully provide care for children in various systems, we must begin by acknowledging that the structure of the environment that treatment is delivered in creates an "Us versus Them" posture. In our training as professionals, we are taught that we must never become emotionally involved. We must always know what is best for the children and simply that these kids are there to

be treated.

Going one step further, there is little tolerance for the concept of love in so many of these therapeutic environments. Unfortunately, we have thousands and thousands of children being raised in environments that are supposed to be therapeutic but the absence of love permeates.

It is essential to bring the personal and the professional together. We must bridge that gap in order to develop authentic relationships with children in care. As professionals, we cannot walk the journey of recovery for children and their families, yet we can hold the light to guide them on their path, being mindful to reflect back to them that they are loveable and there is a place for them in this world where their full expression of self is welcomed and honored. We can hold the vision of hope when they cannot.

We must take into account the context of the child and the family system that they negotiate every day and address the whole, including the physical, emotional, and spiritual aspects of each individual. In doing so, we will create an empowerment-based recovery model where these children and their families will not be blamed or labeled, but valued and witnessed in their healing. I can best illustrate my points by sharing a story about a girl named Kristy.

Kristy was born to young parents. Her mother had bouts of clinical



depression and abused substances and her father came out of a family system where there was substance abuse and extreme neglect. The marriage was marked by domestic violence perpetrated by the father. In several instances, as an infant and toddler, Kristy was left alone for long periods of time resulting in injuries that required medical intervention.

On one occasion it is reported that the mother attempted suicide by attempting to gas herself and her children. The mother was hospitalized a number of times for suicidal gestures and ultimately the father was impacted by mental illness and homelessness. This young family can best be described as being chaotic and in perpetual crisis. We are all familiar with such families.

At age 4, the original family split and Kristy spent much of her early childhood shuttled between grandparents, her father, and her stepfather and mother. It was her mother and stepfather who ultimately, for lack of a better word, raised Kristy. This family, again, was organized around chaos, dominated by crisis and emotional abuse.

Between ages 5 and 9, there were several incidents reported of severe neglect or abuse marked by humiliation, including one incident where Kristy arrived in urine soiled clothing at school as a punishment for wetting the bed. She had been told that if she was going to behave like an animal, she was going to be treated like one.

Her childhood from age 3 on was marked by episodes of acting out, severe temper tantrums resulting in injuries to property, herself, and her peers. Ultimately, Kristy was expelled from school in fifth grade, was deemed severely emotionally

disturbed by the State Children's Services Division and her parents readily relinquished custody.

Although Kristy had repeatedly come to the attention of the school personnel, they struggled with a common experience of having their hands tied and only acted after Kristy assaulted a classmate. The intervention by the Children's Services Division included one option—residential care due to the presenting severity of behavioral acting out. There was no family intervention attempted.

Based on the family history, it does not necessarily indicate a positive outcome would have taken place. However, it was never even attempted. Kristy's first residential placement was at age 10, lasting seven months. After an incident of running away she was arrested on a status offense and housed in the juvenile justice system for three months. She was kept in seclusion most of the time because of her age and presumed vulnerability to the general population. She was then moved to a private psychiatric facility for seven months and then transferred to the Oregon State Hospital for a placement of two years. Her diagnosis was never shared with her. She only knew she must be crazy because, in fact, she was 11 years old and in a maximum-security unit at the State Psychiatric Hospital.

Kristy's experience in institutional care consisted of being warehoused in a rigid system of behavior modification, seclusion, restraint, and forced medication. The messages that were conveyed to her consisted mainly of: "If you are good enough, you will get to go home." Although as it turns out, her family never intended for her to return. She was

the identified patient. Her behavior was under constant scrutiny.

And yet, the very system that was charged with treating her never addressed the extreme impoverished environment she had attempted to navigate with the skills of a child. In her time at the state hospital, Kristy reports that there was one exceptional person who held the light for her. He was the one person that allowed himself to let down the professional guard, make an authentic connection with her, and tell her that she did not belong there, that she could have more.

She saw herself through his eyes, quite probably one of the few times in her life that what was reflected back to her was hope for the future and her human goodness. To this day, she credits him in part with planting seeds of hope for her future.

Kristy left care at 15 and lived on her own from that time forward. Her late adolescence and early adulthood were characterized by periods of incredible responsibility and success and many difficult times of making due. In her early 20s, she experienced periods of extreme depression and ultimately entered the psychiatric system again for intervention.

After several years of cycling through hospital stays, marked by significant suicidal ideation, she was fortunate enough to receive treatment in a pilot program that was geared for young adult women who are high hospital utilizers. They also had to have a trauma background. Kristy was in intensive outpatient treatment that was based on an empowerment model. She was seen three times a week for three years. In this process, she was witnessed and allowed to explore the trauma that was related to her



family of origin and the trauma of being institutionalized. She was supported in attaching to the foster parents who received her out of this Oregon State Hospital and began to explore how to be a part of a family system.

She gratefully acknowledges the Connaway family and especially her mom and dad for the love and support through the labor and intensive process of becoming part of a family, learning to be a daughter. Had you told Kristy at age 10 or 12, or even age 25, that she would one day share the stage with Rosalynn Carter and other esteemed advocates of the rights and well-being of children, she would have thought that perhaps you should be locked up right beside her.

In what seems like another lifetime ago, I was Kristy Ross. Born to a struggling family in Portland, raised by strangers at the Oregon State Hospital in Salem, finding ways to survive and somehow thrive, having contacts to family in Portland, Seattle, the high desert of New Mexico, and now here in Atlanta—I stand before you as a product of the systems we are talking about here today. Although it is at times unfathomable to me that I could survive the experiences of my childhood, the throes of my adolescence, and the painful healing process of my 20s, I did. Although for many years of my life I felt like I was dying a little bit more every day, at some point I moved from surviving into thriving. When given the opportunity to explore and express my rage at the injustice of life's circumstances, I was able to begin healing.

I cannot articulate why I survived these experiences when so many other people have not. I

## Initiative Taking Care of Number One

A 12-year-old was referred to the "Taking Care of Number One" program because he brought a knife to school and threatened another child. He was suspended, reported to juvenile court, and put on probation. He was referred to our program. We were able to understand contextually what this child was living with: a mother who is illiterate, had 11 children, is a victim of domestic violence, and had never been out on her own.

She was a very good mother who protected her children and took care of them. This was the first time he had ever been in trouble. He was actually a very good student at school. We discovered that she was the one who needed empowerment. What she had been doing all along was protecting her children by keeping them home. This young boy had never learned how to deal with other children. Other children at school were far more aggressive than he was. To deal with this, at some point, he had to do what they did. It was not his choice. That was not his natural way of operating.

All of the work was done with the mother, helping her to learn how to negotiate her way through the systems, helping her to call Georgia Power and get her power turned back on, helping her to identify with her own strengths, and being in a group, which was an amazing experience for her. She had never sat around with a group of women and talked about life.

The bond grew among the women—it always grows—and they become a community unto themselves. So when the program is over and pulls away, we leave them with a new context. They now have new friends with whom they have learned similar new concepts that are going to be helpful and hopefully make life more meaningful and joyful.

cannot find words to wrap neatly around the elusive concept of resilience. I know that I am not alone. Many of us have stories to tell. Many of us, or the ones that we love, were children who were forgotten, discarded, and, in some cases, destroyed by the systems charged with our care. How do we bring the fullness of our personal history and experience to our professional work in a way that is both respectful and respected? How do we model well for the children we work with the potential for survival, recovery, redemption, a life worth living? How do we build on the

good and the innovative work that has been described here and inculcate change in all systems that are raising children in this country? We must incorporate into our treatment of families and children an acknowledgement of the importance of personal and community connection, the value of story and being witnessed, understanding a family history and legacy and, yes, that the possibility exists for everyone.

I would like to read a quote by author Belle Hooks from her book *Salvation: Black People in Love*. This quote sums up my thoughts in a way



I have not found through my own words. "Love is profoundly political. Our deepest revolution will come when we understand this truth. Our love can give us the strength to go forward in the midst of heartbreak and misery. Only love can give us power to reconcile, to redeem, the power to renew weary spirits, and save lost souls. The transformative power of love is the foundation of all meaningful social change. Without love, our lives are without meaning. Love is the heart of the matter. When all else fails, love sustains."

*SUNAINA JAIN, PH.D., EXECUTIVE DIRECTOR, NEW LEARNING CENTER, TUCKER, GEORGIA, THE FOUNDER OF TWO ORGANIZATIONS TO HELP WOMEN AND THEIR FAMILIES, DR. JAIN HAS WORKED AS A PSYCHOLOGIST IN PRIVATE PRACTICE AND ACADEMIA.*

During 25 years of working with children and families as a psychologist, I have had the opportunity to get to know children and families up close, to see the world from their perspective. In doing so I get to work with a great number of agencies including the Department of Juvenile Justice, juvenile court, the Department of Family and Children Services, mental health, and school systems. One of the things that has really struck me over the years is that we are dealing with the same people and the same problems, but our perspectives are so totally different. Then a metaphor came to me. It helps me stay focused. If you wanted to feed your child a healthy, balanced meal at home, it consists of the right amounts of vegetables, proteins, carbohydrates, and is low

fat. You can put together a beautiful meal for your family and present it and your family thrives on it.

Now let us say we take this very healthy meal and we decide that we now need to produce this for hundreds of thousands of people at the same time. What happens? We see the results. Watch what children eat for lunch at school. Ketchup passes for a vegetable. Pizza and fries are the typical children's lunch. Something valuable gets lost when you take what we know works on an individual, small-scale basis and suddenly apply it to hundreds and thousands and millions and the whole world all at once.

What happens in the mental health system? Taking that food metaphor into the mental health system, what happens to our intentions? What happens to what we want each child to be able to receive as we now have tried to institutionalize this care? We have to know, what are the critical ingredients? What are the ingredients we want to be sure are retained in this mass produced meal that will nurture and truly help the children become healthy?

## **Context**

There are two or three basic issues that need to be addressed. We tend to focus only on children's behavior, the offense that they have committed, the behaviors that bring them to our attention. It is easy to forget when you institutionalize a program that children live in families, that they go to schools, that they have individual characteristics. They have temperaments. They are born wired a certain way and then that sort of unfolds as they get older. When we do not consider the

context in deciding how to treat the child, we miss the opportunity to make a real difference.

The program I run called the New Learning Center is designed to help single mothers. Many of these children grow up in single-mother families. Yet there are almost no resources available for these mothers. I often will get a referral on a mother and cannot see her because her child is being seen somewhere else or the child is in care or is in custody. How does she get help for herself? It is these single mothers we turn to and ask to take these children back and continue to raise them and help them become healthy.

One of the groups we have created a program for is mothers who have children in the juvenile justice system, "Taking Care of Number One." We go to the homes of the children who are referred to us and we bring them once a week into a group where they receive group therapy. The mothers are in a concurrent group, so while the children are attending a group, the mothers are discussing the same concepts as the children.

The entire program is based on what we need to become healthy, whole human beings. We do not spend a lot of time talking about the offense, bad behavior, or how to be obedient. We talk about how to take care of yourself. I call it the A, B, C, Ds of taking care of number one. It is Advocacy, Boundaries, Choosing well, and Dignity. If you have that, you have everything. It is a somewhat different way of approaching these kids. When these children come to group, they have all had multiple offenses on their record, but we never have had a behavior problem from any of them. Discipline is never an issue.



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## Emotional lives of children

We have an overemphasis on behavior and control of behavior and end up neglecting children's emotional lives. We respond to children who agitate at school or at home or in the community, but not to a child who is just depressed and not acting out. This is why screening and understanding each child individually is so important. Whether we are talking about the child with Attention Deficit Disorder in a classroom or a rebellious teenager who needs detention, beyond control there is an emotional life. It is this emotion in our life, the belief that a person holds about themselves, that drives their behaviors, their relationships, their work, their decision making. How we are in the world depends on how we feel inside. It is this "inside" that we do not pay any attention to, especially when it has to do with kids.

The mental illness, the mental health problem is not always inside the child. Psychological problems are created and intensified by childhoods that do not meet the child's basic needs and protect them from harm, creating feelings of insecurity and uncertainty about how they are going to make it. We have these inner problems that lead to behaviors that often are misdiagnosed as ADHD. So ADHD gets over diagnosed with an endless search for the right medication, the right dosage medication, the right combination. The diagnosis of ADHD far exceeds its actual incidence.

This overemphasis on behavior is reminiscent of this ideal that someone who is passing out from malnourishment should be given smelling salts. It will not change anything. He will pass out again.

## Sense of connection

We hear a lot about love and the need for relationships. These are fairly recent notions to come into our thinking about what children need when they are entrusted to our care. What we need for survival is to be safe and to belong somewhere. All of our survival depends on being attached, being connected to others. That is how we know our needs are going to be met.

That connection is getting harder and harder for many children to have in a society where children live in single parent homes. Even when there are two parents in the home, both work. We are all connected to this intensely, incredibly material driven world. In poverty, divorce, lack of time, preoccupation with material things and the incidence of abuse and trauma create a state of disconnect and lead to lack of empathy among the children. They cannot learn to be empathetic and concerned about others if they have not experienced it for themselves. This leads to the inability for love and trust.

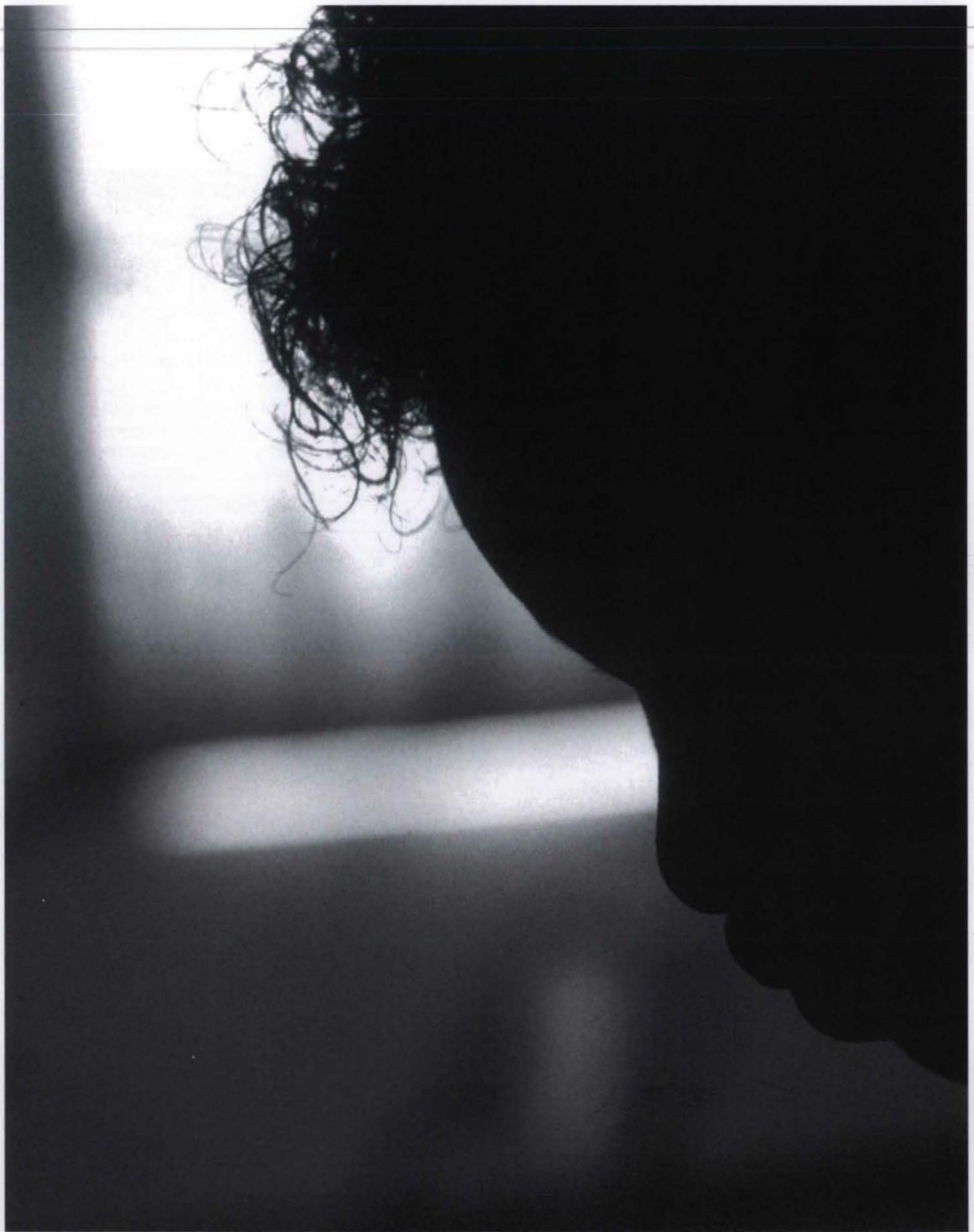
The current *Newsweek* cover article is about evil and there is some talk now about how one of the roots that they talked about is the lack of connectedness that is leading to a more self-centered focus. We are not working together. Everybody is looking out for themselves. The punishment based approaches that we take towards children are clearly not producing results or bringing in a greater awareness of their emotional needs. Recognizing the context for them—where children live and grow—is extremely important. If we punish children without providing for their emotional needs, then we are not doing anything to raise future citi-

zens who will be able to carry on and take charge of this world.

What is it that we need? We cannot assume that we understand childhood simply because we have been children before. There is a lot to know about childhood and about how children become adults, how we socialize them.

What are the critical influences that we must pay attention to? There is collaboration and the need to come together and bring different perspectives. Psychologists and mental health professionals need to play a part. Therapy is not just a 50-minute adjunct. That is often the way it has been seen, a 50-minute thing that happens somewhere away and then life goes on. Yet it is very much a part of everything. Even though we are mass-producing these meals, they are still consumed one person at a time and they still help one person at a time. We really need to nourish these children because there are far too many psychologically malnourished children out there who we are trying to find solutions for.







# A National Perspective— What Can Be Done In Georgia?

*MODERATOR: DOUGLAS DODGE, PH.D., SENIOR POLICY ADVISOR, OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, U.S. DEPARTMENT OF JUSTICE, IN JUNE, 2000, MR. DODGE WAS APPOINTED TO SERVE AS THE SENIOR POLICY AND LEGAL ADVISOR TO THE ADMINISTRATOR OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION. PRIOR TO THIS APPOINTMENT HE SERVED AS THE DIRECTOR OF THE SPECIAL EMPHASIS DIVISION FOR OJJDP.*

*BART LUBOW, SENIOR ASSOCIATE, ANNIE E. CASEY FOUNDATION, A 27-YEAR CAREER IN CRIMINAL JUSTICE HAS SEEN MR. LUBOW SERVE IN A HALF DOZEN DIFFERENT AREAS OF MANAGEMENT, DEVELOPMENT AND INNOVATION. HE HAS ALSO SERVED ON THE BOARDS OF SEVERAL NON-PROFIT ORGANIZATIONS AS WELL AS NUMEROUS STATE AND FEDERAL ADVISORY COMMITTEES.*

Those familiar with the Annie E. Casey Foundation know that a major part of our work over the past decade and a half has been to reform public systems that were designed to serve children and their families, especially poor children and their families. For the past decade I have been immersed in juvenile justice systems around the country at county and state levels in an effort primarily aimed at reducing those systems' reliance on incarceration, but also addressing some of the other concerns that have been raised.

Juvenile justice, in particular, is a system fraught with euphemisms and very little candor. We do not talk about sentences. We talk about dispositions. We do not talk about

convictions. We talk about adjudications. We do not talk about offenses. We talk about delinquent acts. That tendency to soften the edges is characteristic also of our analysis of what is right and what is wrong with that system. So let me share a little bit of what I have learned about juvenile justice.

First of all, the question of the unmet mental health needs of children in the juvenile justice system is a major hot button issue today. My experience over the past 30 years is that issues about mental health and criminal and juvenile justice are recurring ones that are allowed to surface when public concerns about crime rates diminish.

I must admit that this focus on the unmet needs of the kids in juvenile justice scares me. It scares me both because of my experience with this issue and because it creates the misimpression that the juvenile justice system is an effective therapeutic milieu.

In those jurisdictions where the juvenile justice system has represented itself as a place where kids can get treatment, there has been this large sucking sound. The kids are sucked into the juvenile justice system because of the vacuum of services in the community that would be more appropriate and more effective.

The truth is that the juvenile justice system is a system lost in its own contradictions. Perhaps the most fundamental contradiction is that it is a system that was created with a mission to serve the best interests of the children, yet it is a system that has historically over

## **Bart Lubow:**

**Q** Are you familiar with efforts in other countries to effectively treat troubled kids, steering them clear of juvenile justice?

I am not as familiar as I might want to be. I am familiar with efforts in Western Europe, in particular. We are actually helping fund a comparative analysis of how different countries with similar forms of government are handling juvenile delinquency issues, but I am not familiar with the different interventions.

## **Andres Pumariega:**

**Q** When the judge enjoined the juvenile justice and mental health systems in South Carolina, one, what did that mean, what happened? And two, what caused that to happen? A lawsuit?

Enjoining means that the agency becomes the defendant in the lawsuit. The original defendant in the Alexander S. lawsuit was the State Department of Juvenile Justice. However, the judge, after about three or four years, enjoined the other child serving agencies. Part of it was out of the judge's frustration with things not moving fast enough. He felt that some of the solutions in addressing the multiple needs of youngsters coming into juvenile justice were not being addressed as comprehensively as they could be with juvenile justice being the one in the hot seat and the other child serving agen-



incarcerated kids. Whether it is the system neglecting those children in its care or whether it is probation caseloads that exceed 100 or 150, or facilities that fail to pass constitutional muster, the system has been lost in its own rhetoric and has failed to recognize its own shortcomings.

Throughout the country thousands of kids are being unnecessarily confined. These kids are in there often for minor acts.

If you go to detention centers and you observe the lack of significant interaction between staff and the children in custody, if you examine the unseemly reliance on room confinement, you will begin to understand the challenge. If you check out the growing use of chemical restraints—not psychotropic medications, but Mace and pepper spray—if you go into those facilities and observe these practices nationally, you will know why it is improbable, if not downright dishonest, to propose that the juvenile justice system is prepared as an effective venue for meaningful therapeutic interventions. Even if you look at the supposedly benign interventions and innovations of the past few years, the system's ability to provide those kinds of interventions becomes questionable.

The largest move in regard to the mental health needs of kids recently has been the development of so called assessment centers. A variety of paper and pencil exams are applied, and kids are supposedly referred for services. In my experience, assessment centers have succeeded in the following: they have created a new assessment center industry; they have significantly widened the net of social control; and they have often times violated the fundamental due process rights

of the children in their custody.

They also have done all these wonderful things while utterly failing to significantly increase the delivery of relevant services to youth or their families.

We need to acknowledge in looking at the juvenile justice system that our nation's historical ambivalence about adolescents has become one of outright hostility. The criminalization of delinquency, best reflected in the move toward prosecuting more and more youth in the adult court system and incarcerating them in adult prisons, has blurred further our already limited understanding and capacity to distinguish developmentally between kids and grown ups.

One final comment about why this system likely is not the proper venue for treatment. The kids in our juvenile justice system, and especially those confined in detention and correctional facilities, are overwhelmingly kids of color and poor children. The reality is that we have two systems of juvenile justice in this country. We have an informal system in which considerable discretion is applied, cases get resolved in people's living rooms. The kids who are in custody and the kids therefore who are in the juvenile justice system with unmet mental health needs are predominantly kids of color or poor children.

During the period from 1985 to 1995, America's reliance on secured detention almost doubled. The detention rates for white children actually declined by 7 percent during that period. For African-American kids, they increased by 180 percent, and for Latino children they increased by 140. These increases have nothing to do with relevant increases in the rates of offending.

They have to do with a dual system of justice that we have all established and allowed to continue.

So what are the implications of these findings or these observations regarding the juvenile justice system's capacity to respond to the mental health needs of children? The first order of business has to be to do no harm. The systems have to stop making children sicker.

In addition, there are at least four things that a good juvenile justice system ought to be able to do about the mental health needs of its children in the short term: One, to effectively identify children who pose serious suicide risks and ensure that they do not harm themselves; Two, to determine which of the children in their custody are receiving medication and to be able to administer that medication in a timely and accurate way; Three, to ensure that children who are released from their custody and who are being treated are released to community-based providers who will sustain that treatment, including those medications; And four, to be able to respond to acute episodes when they occur while kids are in custody. Most juvenile justice systems do a bad job on all four of those points, but there are things that we can do and do effectively if we devote ourselves to them.

What are the broader implications of this analysis for the issues of young people who are involved in juvenile justice and also have mental health problems? Other systems that are supposed to be serving children have got to stop dumping kids into the juvenile justice system.

The problems that young children present to us are rather unlikely to be resolved by a stranger sitting on a bench with a gavel and a black robe with whom they have



little familiarity and no meaningful relationship. The notion that sanctions are going to change those behaviors in meaningful ways has simply not been borne out by our experiences.

Similarly, we have to focus on building community-based systems of care. Let me say one thing about those systems of care from the perspective of someone who used to be a statewide probation administrator. It is hard to understand what we do in juvenile justice with children who are on probation or community supervision. We think that 10 minutes a month in a probation officer's office is some kind of intervention and we do nothing with the families. It makes no sense to me at all. Those evidence-based programs that have made a difference in altering the trajectory of troubled youth's careers are ones that deal with children in the context of their families and view the family as the client and not just the child.

**ANDRES PUMARIEGA, M.D., PROFESSOR OF PSYCHIATRY; EAST TENNESSEE STATE UNIVERSITY, DR. PUMARIEGA IS A FELLOW OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, AND THE ACADEMY OF PSYCHOSOMATIC MEDICINE.**

I want to describe how a child psychiatrist gets involved in a CRIPA lawsuit, CRIPA meaning Civil Rights of Institutionalized Persons Act. That is the kind of lawsuit that is being brought against the State of Georgia as well as the juvenile justice system. Specialty child and adolescent psychiatry was

not being a part of the lawsuit.

Part of the difficulty with that lawsuit, and in some ways many CRIPA lawsuits, is that they tend to focus on the detained or incarcerated population.

**David Shaffer:**

**Q How can we in Georgia gain access to the diagnostic tool that you referred to? It appears to be working very well in neighboring South Carolina. What kind of background is necessary? Is there a cost?**

Well, the tool is available. It was paid

for by the government. And it has since been elaborated. We would like to see it used wherever it can be useful. It was originally developed for such, but the interest in using something like this in a service setting is so great that we have modified it. We would like to cover our costs and that is about it. The training that is required, if you use the voice DISC, is restricted to interpreting the findings because the use is very straightforward. It is very simple and very flexible in how it can be administered. So it becomes a matter of what you interpret and what you make of the report. The importance of the diagnostic evaluation is that it allows you to focus on events and circumstances.

in part born out of the juvenile justice system back in the 1890s when the juvenile courts were first formed. At that time they formed court clinics and that is where some of the first child mental health work began.

In my training, I was supervised by a gentleman named Harold Harris, a great child and adolescent psychiatrist who did much consultation work in juvenile detention facilities. He was actually the main psychiatric consultant in the Willy M. lawsuit. Then I arrived in South Carolina to head a child psychiatry program in a public academic setting and my department chair said: "The Department of Juvenile Justice is being sued. Go help them." The issues we faced in that lawsuit, which is called *Alexander S. versus SCDJJ*, were an inadequate health and mental health facility, overcrowding, and mental health staffing. There was tremendous overcrowding, sometime 60 youngsters in a cottage with only one JCO supervising them. The

state of South Carolina faced similar issues that Georgia is dealing with.

At the University of South Carolina, we got involved at a number of levels. We first developed the residential level facility within the main juvenile justice campus staffed with a full mental health team. There we served the most seriously mentally ill youth, the youth who were identified under the class action lawsuit. We had problems maintaining the structure of that program within the mental health campus and unfortunately had to move it within the juvenile justice campus.

Once we got the residential program stabilized and serving the most severely ill youth, we were able to replicate that program to serve a larger number of youth. Two successes that we had were in tying in case management very closely to the community and to the various community mental health centers in South Carolina, as well as



involving families. We had family support groups. Unlike the stereotype of families of youth in juvenile justice, the families were still committed, still cared, and came.

We expanded the psychiatric consultation to the detained youth and access to inpatient facilities. We developed a high-management inpatient unit for the youngsters at our institute and planned for community-based services.

We also fielded a study that was a cross between a needs assessment and an epidemiological study. This study looked at three groups, controlling for region. A sample of 75 incarcerated youngsters in the center facility in Columbia, comparing them to 50 hospitalized youth and 60 youth treated in the community mental health center, all from the middle region of South Carolina. These were randomly selected kids. We used an instrument developed by Dr. Shaffer: the Diagnostic Interview Schedule for Children, Version 2.3. We also used the Child Behavior Checklist and data from the records in the detention facility.

Our results were quite striking and served as a catalyst for some of the later work. We found that in that sample of kids, incarcerated youngsters, 72 percent met criteria for at least one diagnosis on the Diagnostic Interview Schedule for Children (DISC). Fifty-three percent of the total sample met criteria both for at least one diagnosis on the DISC and also for the cut off on the child behavior checklist clinical cut off score. The average number of diagnoses for youngsters was 2.4 compared to 4.2 for hospitalized, and 1.6 for youngsters in the community mental health center sample. So these youth, in terms of severity of difficulties, were right in

between the hospitalized group from their same region and youngsters being served in the community mental health centers.

When we looked at their prior service utilization, we found that these youngsters had used significantly fewer prior mental health services in their service history before coming into detention but used significantly greater residential services, i.e. being placed out of home and in non-therapeutic facilities.

These were not all youths with conduct disorder. These were kids suffering from anxiety disorders and mood disorders. Forty-five percent met criteria on the psychosis screen of the DISC, so they had some form of psychotic symptomatology. Schizophrenia though, is probably not in the great majority. Delinquent mood disorders are possibly linked to post traumatic stress disorder, or PTSD.

Substance abuse disorders were probably underreported at 20 percent. But again, there was a wide range of different disorders that these youngsters dealt with.

The study was used as a catalyst. The state went on to decentralize their facilities. They have designated one campus to treat youngsters with substance abuse and there was a greater emphasis on developing community-based services with a greater focus on diversion.

The real eye-opener in terms of what was possible came two years ago in a project of the American Academy in Child and Adolescent Psychiatry funded by the Center for Mental Health Services (CMHS), where we continue looking at best practices and collaboration between mental health and juvenile justice in communities. The workgroup that I chair has visited many sites

around the country. One of the exemplary sites that we found was in South Carolina. It was the Village Project in Charleston. These are demographics of the youngsters served there. Sixty-two percent are male, 70 percent African American. Their mean number of contacts with the law was 1.8 per youngster with 88 percent having at least one legal contact, 42 percent having at least one arrest, and 7 percent having at least one felony. These were fairly tough kids.

This program, through its community-based, interagency, interdisciplinary approach, reduced incarceration by more than 80 percent. In fact, it has sustained that, even post grant. This is no longer grant funded by CMHS; this is now a self-sustaining program.

They also have reduced inpatient utilization by similar levels. I witnessed this while heading the inpatient services for the state as part of the University of South Carolina. We saw the declining numbers coming from Charleston. This was evident even before my departure in 1996.

The Village Project took a number of approaches. They developed an inter-agency council that represented all the various agencies serving children. They quickly developed school-based mental health services. They now cover 50 out of 77 middle schools in Charleston and have 17 full-time staff devoted to school-based mental health services. They also have a community mentoring and vocational program for after school interventions.

They also have taken one of the tougher populations. They have served more than 300 youth with sexual offenses through intensive behavioral intervention and cognitive behavioral therapies. They also have



intensive community case management, wraparound and home based services, and psychopharmacology services. They weave all these into an individualized wraparound approach targeted through the youngster and driven by the family.

They also have a number of other collaborative activities. They have a cultural competence initiative across agencies. They now have mental health staff at the detention center to quickly serve youngsters upon detention. They have weekly child and family consultations where the whole interagency team sits with the family and lays out what their needs are and what the youngster's needs are. And the agencies respond.

They also have a youth drug court with the judge serving as the case manager. The judge tracks the youngsters' improvement coming off of substances, working with probation officers, case managers and assigned master's level therapists.

They also have the most incredible family advocacy approach I have ever witnessed. They not only have paid family advocacy coordinators, but also a volunteer program of more than 50 parents who have devoted themselves to advocating for families entering into the juvenile justice system. Collaboration is the key—not only at the local level, but also paralleled at the state level.

The importance of community-based systems of care approach, preventing institutionalization, and facilitating community integration also is high. This not only includes community-based interventions, the role of family advocate, and culturally competent interventions, but also integrating clinical and support services. There is tension between the advocacy for psychosocial sup-

ports and advocacy for clinical services. Yet they are not incompatible. They need to be woven together.

The best that the evidence-based approach has to offer, as well as the best the systems of care approach has to offer, have to be brought together in these programs.

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I was invited to talk about techniques for screening and identifying psychiatric disorder in juvenile offenders. But I feel there is a need for me to preface whatever I am going to say with some comments. There clearly have been references of a slighting kind that reflect the polarity, or the polarization, of mental health professionals in the field at this moment. That often takes the form of references to medication as being perhaps the simplified approach to treatment as opposed to a more humane approach; references to behaviors perhaps suggesting that diagnosis is not that important and reflects more important underlying cognitive processes. And references also quite frequently to generic styles or ways of handling the problems of mentally ill young people.

This is a problem that actually permeates and, to some extent, does irreparable damage to the mentally ill throughout the country, much

more so for the youth than for the adult. Everybody is aware that if you look at the juvenile justice system, if you look at the mental health system for adolescents, if you look at the social welfare system, if you look at the special education populations, you will find a great similarity in the kind of kids who are in each. To some extent, the allocation of very similar young people to their systems is a function of opportunity and prejudice, but it is also to some extent a function of this split within the mental health field between people who see mental health problems as a fairly generic uniform problem and those who really are struggling to try and differentiate amongst the mentally ill those who have different kinds of disorders that might require very different kinds of management and treatment.

These are not just differences in training or orientation. They are differences that have a major impact on how we assess, view, allocate, categorize, and designate young people in this country at the moment. We probably do it better than any other country in the world and it is a problem that is international and universal.

As a proud child psychiatrist, I would like to say that there have been enormous advances in mental health over the past 15 years of a kind that we have never seen or known about before.

One of the most striking measures of these advances has been the drastic reduction in the youth suicide rate. Suicide in adolescents is always a consequence of an underlying mental illness. Since 1988, we have seen a nearly 30 percent decline in the teen suicide rate. This is not peculiar to the United States. We have seen that in all



other developed countries where there has been the widespread introduction of medications of an important and powerful kind.

So it is important that we not dismiss a diagnosis and very specific treatments as lacking humanity or lacking sensitivity to the terrible lives that many of the youngsters in the system will have endured. We also must recognize that the extremes of parental behavior may themselves be a reflection of mental illness in the parents and in those families. We cannot separate deviant family practices from the great importance of the impact mental illness may have on child rearing and on a sensible sensitivity to what is going on with the child. Often the interplay between a very specific psychiatric problem and the ultimate consequence in deviance is very complicated and very subtle. Two cases come to mind:

One is of a young 14-year-old girl I was asked to see initially about two years ago. She lived abroad and was having problems at school. The family wanted to know what I thought of it because she also was being very disobedient and she had had two years of therapy and nothing much was changing. When I interviewed her, she had very significant obsessive-compulsive disorder symptoms that had never been recognized.

In the classroom, she was totally preoccupied with counting and categorizing things in the room and putting them together. When she tried to write an essay she would take certain key words that were in the first paragraph and have a compulsion to repeat them right through her piece of written work. Those were never recognized as pathological. They had not been picked up by people who had not been trained

in diagnosis or not been oriented to diagnosis. The net effect was that she was expelled from school, that her behavior continued to deteriorate, and I got a call last week to say that she was in prison.

The other is a young boy I was asked to see when he was 13. He also had failed repeatedly at school and nobody understood why. He had such an odd learning disorder. We did an IQ test. He had a verbal IQ of about 128, which is very superior, and he had a performance IQ of about 92. So there was more than a 30-point discrepancy between the two.

We know that this is associated with certain types of brain damage. We also know that it is associated with learning difficulties of a kind that are not obvious to many people. This boy had failed repeatedly in school. He became a casualty of the education system. He was sent away to a special school where he affiliated with others. He got involved in gambling and then stole to meet his gambling debts, including his computer gambling. And again, this week he is going off to incarceration.

So the interplay, a very subtle and difficult to discern psychiatric component, and how this might in turn eventually lead to very uniform kinds of results, is important and it offers us the way to exhibit skill in a setting of this kind. The consequence of policy is that maybe what we need is not so much more training, but different kinds of training. We may need to enlist people who are available because there are many mental health professionals in the country.

I also would like to offer one other example. It is from Boys Town of America. The home campus in

Omaha is an impressive place. Each unit is broken down into bungalows. They have very dedicated house parents. They have taken kids from courts all over the Midwest and applied a very generic, single modality type of treatment. It is one of the best, the Rolls-Royce kind of behavior therapy in which you praise people for doing good things and you ignore them for doing bad things. Of course, it is difficult to ignore kids making suicide attempts and so on, although you could not really fault the particular mode of treatment they were applying.

Using diagnostic information, they were able to modify and modulate what was previously a generic uniform mode of management into something that fitted the needs and the handicaps of the children they were seeing.

In the rates of specific diagnosis, status is prevalent depending on the study of kids with a disruptive disorder, between 7 and 22 percent in the general population. For the most part, 40 to 45 percent of offenders will meet those criteria, which is not very surprising. That should not be the reason why we think that mental illness is a problem in detained groups or offender groups.

Substance abuse disorder has a prevalence of about 6 percent in the adolescent population in the community. When we get to the incarcerated group, we are reaching 30, 40, 50 percent rates. The relationship between substance use and mood disorder, suicidality, and aggressive behavior is extremely profound and very powerful. Two thirds of all adolescent suicides, adolescents who kill themselves, have a history of alcohol intake or other substance uses.

This is a very powerful stimulus



for mental illness. The need to treat this in a way that is going to somehow minimize the likelihood of recurrence after discharge is considerable.

Mood disorders have a prevalence of about 2 to 3 percent in the adolescent population whereas in the incarcerated group we are getting 10, 24, 14, 19 percent, rates five to six times what you would expect.

Finally, anxiety disorders also are very important causes of morbidity and handicap and a predisposition to depression. These are present at astonishing rates—33 percent, 36 percent, 22 percent—in the incarcerated population. Anxiety disorders hardly ever are recognized. They often are seen as being a feature of the child's personality. In fact, they are highly treatable, very important contributors to much of the handicap that will afflict somebody with a mental illness.

In the general population, there

is a very high rate of suicide ideation and attempts, predominantly in 15-, 16-, and 17-year-olds, where it reaches a peak. From the youth behaviors survey, about 17 to 19 percent of teenagers will have thought about suicide. Five to 8 percent will have attempted it in the last 12 months. The only study that we know of using comparable methods in offenders shows ideation of 10 percent in the last four weeks and suicide attempts of 3 percent in the last four weeks.

Screening youngsters for diagnosable mental illnesses is a procedure that can be done at different levels. It is very common for people to use a quick checklist on admission. The trouble with those instruments is the results do not give you any guide as to what kind of treatment or what kind of management or disposition you should make. They just tell you that there is something wrong with the kid.

The alternative is to try and move toward something to assess diagnosis because diagnosis allows you to form treatment plans and to make predictions. One of the things that we have been doing initially in collaboration with the National Institute of Mental Health (NIMH), and more recently on our own, has been to develop this diagnostic interview schedule for children that was originally developed for research purposes, but that has now been modified for use in public settings where diagnostic skills are not widely available. The instrument emulates the behavior of a diagnostician.

At the end of that evaluation, which takes about two hours, but which consumes very little skilled time—no skilled time, really, because it is done on their own—you get a diagnostic report that will list the symptoms present, the DSM

**Q** We all seem to agree on what is working and what is not—family, community, agency involvement, community-based kinds of programs. Since we agree, what is the next step to make something happen?

### **Bart Lubow:**

The first step down the path to changing this begins with political will. The problem with system reform efforts that we have been engaged in nationally is a failure of political will. The failure to decategorize funding, and the failure to hold the people who run these systems accountable for actual outcomes and not for process variables. The problem of genuinely trusting and believing in the power of community-based solutions.

Those things all begin and end with the strength of our political vision and our willingness to make changes at various levels of government to enable this kind of system reform to actually take place.

Our experience has been that an absence of political will results in a lot of rhetoric and some nice PowerPoint presentations, but not many changes in the way we deal with children and families.

### **Andres Pumariega:**

I had a slightly different take. While I was going to say that political will is a major issue, there are a number of things that underlie political will. One of them is what Dr. Shaffer mentioned in terms of some of the divisions about disciplines and perspectives, how to best provide services for children experiencing mental illness and emotional disturbance. We need to come to more of a meeting of

the minds that it is not an "either or" approach, but a comprehensive approach when we marry many of our different perspectives and different intervention approaches.

### **David Shaffer:**

I think that if you look at practices, both historically and across the country, they often are a mixture of somebody's good or bad intuition—whatever seems to be right at the moment. They are very rarely informed by a demonstration of success or of efficacy. It seems to me that in the field of medicine and technology, generally, nothing is as powerful as showing that something works. So my feeling is that the way to go is toward well-planned, well-executed demonstration projects in settings where interventions are possible, and let the results speak for themselves. They may not work.



criteria that have been met, and the DSM diagnoses that have been met. It also records some levels of severity of all of these things.

Those, in itself, are not sufficient, but they do allow an institution to be able to triage certain individuals for a psychiatric or a clinical evaluation. There are now techniques and technologies available that should make this problem more manageable, and it is a mistake to completely dismiss incarceration as an opportunity, because it is an opportunity where some evaluations of this kind that are not commonly conducted in real life can be conducted and more appropriate treatment can be delivered.

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**I**t is always exciting to talk about the Safe Schools Healthy Students program. After being in federal service for about 30 years, this is one of the most unique and most exciting endeavors in which I have had the privilege to be involved. I am going to discuss how we got to this program, a little bit about what the program is, and then hopefully that will lead to some indication of how both the process and this program might be helpful in the State of Georgia. The process and content are both unique and both important.

Briefing Congress on this program over the last couple of years, quite

frankly they were as enthralled about how we got three huge federal departments together to work on a single project as they were about what we eventually came up with. It appears that Georgia has some of the same issues and opportunities that we face.

Before fiscal year 1999, the Center for Mental Health Services really had not been significantly involved in the issue of youth violence prevention. The real impetus for legislation in this regard came with the increase in school-based shootings that happened over the last several years.

Clearly this is not when youth violence started. This is when it became visible and galvanized the country as it began to impact suburban, middle class, white communities. But it has been here for a long time and it is not something to be particularly proud of that we have not addressed it before now. But it is exciting to have the opportunity to be able to do something finally.

The language we got from Congress was very nondirective. It said: "Do school and youth violence and coordinate with the Department of Education." That was about all the guidance we got from Congress.

We went and talked to our colleagues in education with whom we had had some dealings before. We certainly became aware that the Office for Juvenile Justice and Delinquency Prevention (OJJDP) and the Department of Justice had been looking at this issue for a lot longer than we had. So we started working together. This program did incorporate right from the beginning the community-oriented policing service program in OJJDP. We also had started some inter-Substance Abuse and Mental Health Services Administration (SAMHSA) collab-

orations. We worked very closely with our colleagues in substance abuse prevention and treatment.

## **Process**

This journey has been a unique one. We had to get to know each other in a kind of cross-cultural experience. We probably should have had a cultural anthropologist in the group to help us along. Individuals from three different professional and organizational cultures came together. We viewed the problem through different lenses. We used different language. When our colleagues at OJJDP were talking about early intervention, they were talking about pretrial issues. When we referred to it, we were addressing prenatal issues. In public health, when we referred to surveillance, it is different from the justice peoples' concept of surveillance. So there were a lot of language issues to overcome.

It was decided to dedicate high level leadership to this effort, to bring people in the room on a regular basis who actually could make decisions about this, and not just a bunch of us who always had to go back and negotiate with our own agencies.

This process took years. For the first year, we met every Tuesday and Thursday afternoon to get this effort off the ground. For the next year, it was every Thursday afternoon. Now it is every Thursday afternoon every other week. We met literally over a period of years, trying to keep the people involved as consistent as possible. As much as we like to institutionalize these kinds of issues, they are personality dependent and it is important to keep the same individuals at the table.

Amazingly, we worked on a consensus model. Not once during the



years we have been doing this, have we taken a vote on anything in this program. It is inefficient. It is cumbersome. It is tedious. But in the end it has come out forging a coalition of these three departments that could not have occurred in any other way. We moved huge bureaucracies.

We decided not to have three different grants released for this, but a single grant. That meant pooling our money. If you have seen what pooling money is like in the State of Georgia, you can imagine what it is like on the federal level for money appropriated to the Center for Mental Health Services to be given to the Department of Education. That does not happen, but we made it happen in this situation.

## Content

One of the underlying principles that we decided early on was that we were going to marry security with healthy childhood development. We were going to have a public health approach to this with a comprehensive and coordinated set of services across the developmental path.

At a minimum, we were going to require local community applicants to include collaboration between law enforcement, mental health, and education. It certainly was not limited to that. Many of the successful grants involved faith communities, health communities, other major stakeholders, and in all of them students and parents and other interested parties were involved.

Right from the beginning we decide to pay for what works. These funds were not going to be used to develop new kinds of approaches to preventing youth violence. Instead, we found a number of evidence-based programs out there and required that applicants mount an evidence-

based practice that already existed.

It also was decided to invest heavily. That is not an easy political decision to make. The easiest thing to do is spread the money as far as you can so you cover as many states and congressional districts as possible. But if this was going to work we needed to invest heavily in the communities, giving them enough dollars to really give this a chance. These grants are anywhere from \$1 million to \$3 million dollars, depending on the size of the community.

We decided early on to incorporate suicide prevention in the definition of violence prevention. That was largely a result of the constant reminders of advocates. So many of these programs include suicide prevention activities, as well.

We also decided to support a comprehensive approach that talked about prevention and early intervention, promoting healthy child development, acting on known risk and protective factors, and engaging a wide variety of community partners.

What did we get? In our only solicitation for this grant program so far for fiscal year 1999, we received 447 applications and this was with very short notice. They were extraordinarily good applications. In fact, there is one grant in Georgia that was funded in that original cohort.

We initially funded 54 programs around the country. Because the applications were so good, the next year we simply went down the list a little further and now we have a total of 77, representing a federal

investment of about a quarter of a billion dollars. We get a very good representation from urban, suburban, rural, and tribal areas.

This is a new type of approach to federal programming, so we needed to support these grants in ways that typically do not occur. We established a multi-departmental project officer team. We have project officers on this from OJJDP, the Department of Education, and from the Center for Mental Health Services. We established the Action Center, which is a major technical assistance effort. We also set up national, regional, and local evaluation of this program and have initiated a very exciting national education campaign, again, believing that if we are going to make this stick, it really has to involve community and business leaders.

So what is new for this fiscal year? We expect to have about \$34 million available for new programs. The application period is going to be short, probably no more than 60 days. We expect to fund about 10 to 15 new grants, depending on the size and location.

The Surgeon General's report on youth violence is probably the best single source of what the science tells us about youth violence prevention and the nature of youth violence in this country. We are going to embark fairly soon on a number of listening visits, a listening tour by the Surgeon General, to see how communities are using that report, how they are approaching this issue.

## Summation

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This was a collaborative effort of so many different groups. And that is what it is going to take, a lot of collaboration. I hope that is something that we all can agree on.



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## Conclusion

We cannot afford to lessen our attention to the needs of children with mental health and substance abuse problems in the juvenile justice system. There has been a lot of attention paid to children's mental health in the past few years. Some of this is the result of brain research, which has resulted in new medications and new treatment methods. Some is due to positive actions like the Surgeon General's Report on Mental Health with his subsequent conference on the mental health needs of children. Unfortunately, some of the focus is the result of tragedies like the rash of school shootings plaguing this country.

We have an opportunity now to make real improvements in the lives of these children with mental health and substance abuse problems. We must not squander this opportunity. We need to advocate for more and better services for them before they end up in trouble with the law. None of us think that the juvenile justice system is the place to deliver mental health services. But our children are there by default and we have to take care of them. And for those who do get into trouble, we have to advocate for treatment and not punishment. No one, especially a child, should be incarcerated for having a disease.

—ROSALYNN CARTER









National Mental  
Health Association  
of Georgia



Georgia Parent  
Support Network, Inc.



The Georgia  
Mental Health  
Consumer Network



The Carter Center  
Mental Health Program



NAMI Georgia