A statewide collaboration
to screen and connect youth to mental health care
upon entry into Indiana juvenile detention facilities

2011 Report and Recommendations

By Matthew C. Aalsma, Ph.D.,
and the Indiana Juvenile Mental Health
Screening, Assessment & Treatment Project

Indiana State Bar Association
Civil Rights of Children Committee
in Cooperation with the Youth Law T.E.A.M. of Indiana

August 2011

Indiana Juvenile Mental Health Screening, Assessment & Treatment Project Sites as of July 2011

Bartholomew County Juvenile Detention Facility
Clark County Juvenile Detention Center
Dearborn County Juvenile Center
Delaware County Youth Opportunity Center
Elkhart County Juvenile Detention Center
Grant County Youth Services Annex
Hamilton County Youth Center
Henry County Youth Center
Howard County Kinsey Youth Center
Johnson County Juvenile Detention Center
Knox County, Southwest Indiana Regional Youth Village
Lake County Juvenile Detention Center
LaPorte County, Dorothy S. Crowley Juvenile Services Center
Marion County Juvenile Detention Center
Porter County Juvenile Detention Center
Tippecanoe County Juvenile Intake Center
Vigo County Juvenile Center

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(Released August 2011)

Just a few short years ago, Indiana lacked systematic mental health screening for youth in the juvenile justice system. Our state responded by developing and implementing a unique mental health screening model. As a result of the Juvenile Mental Health Screening, Assessment & Treatment Project, as of Jan. 1, 2011, pilot sites across Indiana had conducted more than 18,500 mental health screens on youth at the critical intervention point of entry into detention. The project has expanded to include pilot sites in 14 counties and continues to grow. Each county participating in the project has demonstrated support and cooperation of the juvenile court judge, probation, county prosecutor, defense bar, detention center and the relevant mental health providers.

While efforts have been made to initiate mental health screening programs at detention centers over the last decade since detained youth evidence significant psychopathology, these efforts have primarily been located in isolated facilities with little focus on connection to mental health care upon community reentry. Indiana undertook a different approach in this collaboration to implement a statewide mental health screening program within detention centers. Unique aspects of this project include a focus on maximizing personal protections and enabling connection to care through legislation.

Project report

Approximately 2 million youth under the age of 18 are arrested annually, and on a given day 100,000 youth are held in a detention or correctional facility (Skowyra & Powell, 2006). Youth placed in juvenile detention centers have high rates of undetected psychopathology (Grisso, Barnum, Fletcher, Cauffman & Peuschold, 2001). A recent review of mental health disorders among adolescents in correctional and detention center facilities found that the majority met criteria for mental health diagnoses (Fazel, Doll & Langstrom, 2008). Substance use disorders among youth in the juvenile justice system are also high. For instance, in one study, approximately one-half of detained youth met the criteria for a substance use disorder (Teplin, Abram, McClelland, Dulcan & Mericle, 2002). The high rates of psychopathology have led to recommendations for universal mental health screening for youth in detention centers. However, institution of mental health screening can be difficult; for example, coordination across systems within juvenile justice (*e.g.,* court, detention, probation) can take significant planning and follow through. Additionally, juvenile justice systems can be slow to adapt to new processes as there are many bureaucratic and logistical matters that complicate such a transition. For instance, there are legal barriers that take legislative changes, such as juvenile defenders advising their clients to withhold consent to mental health screening due to possible self-incrimination. Moreover, the information gleaned from mental health screening then demands attention by detention center staff, who already have multiple responsibilities. Even so, eliminating these barriers and linking to care youth involved in the juvenile justice system with mental illness are important, since effective mental health treatment is associated with decreased recidivism (Vermeiren, 2003). The Indiana Juvenile Mental Health Screening, Assessment & Treatment Project (Indiana Project) is an initiative that seeks to address the above barriers in order to implement mental health screening and enable connection to mental health care in detention centers across the state.

The concept for the Indiana mental health screening pilot program arose from the Indiana State Bar Association's (ISBA) Children, Mental Health & the Law Summit, held on Aug. 27, 2004. The Summit resulted in a published report with Indiana-specific recommendations for implementation of mental health screening in detention centers. The ISBA then pursued funding through the Indiana Criminal Justice Institute to establish the Indiana Project, which was modeled after a similar statewide effort in Pennsylvania, with a few distinguishing differences. The Pennsylvania Project's goal was to screen all youth entering the juvenile justice system for identification purposes in order to provide improved, targeted services for the duration of the detention stay. The Pennsylvania Project was organized by the Juvenile Detention Centers Association of Pennsylvania and sought to improve services and connection to mental health care within the detention center for those youths identified with a mental health diagnosis. The project utilized the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2), a brief screening tool designed to identify youth who were in need of further evaluation. Fifteen of the 23 juvenile detention centers (JDCs) in Pennsylvania screened 18,607 admissions over a 2-year period (Cauffman, 2004). Through the statewide Pennsylvania Project, it was found that participating detention centers were better able to identify youth with mental health needs and, as a result, improve services. For instance, mental health screening improved staff perceptions of youths and facilitated communication between staff and youths (Williams, Grisso, Valentine & Remsburg, 2008). As staff became aware of the prevalence of mental health issues, they became better able to adjust their responses to behaviors exhibited by youth. Moreover, many Pennsylvania detention centers were able to use

the data from the MAYSI-2 screenings to secure additional funding for better mental health services within the detention center (Williams *et al.*, 2008). However, E. Cauffman, in 2004 in the *Journal of the American Academy of Child & Adolescent Psychiatry*, suggested that identification alone was "not ... sufficient to improve the effectiveness of rehabilitation efforts." As a result, the Indiana Project made connection to mental health care upon release from detention a central goal. To achieve this goal, the Indiana Project State Advisory Board recognized a need to: 1) maximize protections regarding self-incrimination for detained youth; 2) standardize protocols across county systems; 3) share sensitive mental health information across systems to care for detained youth; and 4) limit barriers to effective mental health care upon community reentry.

Protect against self-incrimination

Items within the mental health screening instrument may reveal behaviors considered to be a crime during adolescence, including substance use and other antisocial behavior. Hence, endorsing specific items may allow for a youth to be charged with additional crime. Furthermore, youth, in the midst of a mental health screening, could mention details of a crime that they may have committed. That information could be used to prosecute the youth for the crime mentioned, instead of being used for obtaining services for that youth. Thus, it is possible the screening process could lead to more charges being filed rather than appropriate care for the underlying mental health issues. This potential for self-incrimination presents another deleterious effect, namely the deterrence of youth from consenting to the screen due to fears of prosecution. If youth refuse the screen, the amount of youth screened decreases, which reduces the overall effectiveness of the universal mental health screening process. As such, a need was noted to protect youth from self-incrimination. A unique feature of the Indiana Project is the partnership with the ISBA. This has resulted in strategic advantages in the planning and implementation process, as well as in addressing barriers, such as self-incrimination.

The State Advisory Board, which is housed at the ISBA, oversees the Indiana Project and meets on a bimonthly basis. The board consists of interdisciplinary individuals representing juvenile justice (for example, judges, lawyers, detention center superintendents), mental health professionals, local and state agencies (Division of Mental Health & Addiction; Department of Child Services), interested professional groups (Indiana Chapter of the American Academy of Pediatrics) and relevant university and community partners. In partnering with the ISBA, the Indiana Project has obtained a strategic advantage in building consensus around reform and eliminating barriers rooted in state public policy, including legislative advocacy.

The ISBA has helped lead collaborative efforts to amend state laws that are pivotal to achieving a continuum of care for youth in detention. For instance, the ISBA enlisted the help of collaborators in the pilot project to obtain passage of legislation that protects screened youth from prosecution as a result of knowledge gained during the screening process. The Indiana General Assembly enacted House Enrolled Act 1339 in February 2007, and it states that information given by the child to an evaluator during mental health screening, assessment, evaluation or treatment "may not be admitted as evidence against the child on the issues of whether the child committed a delinquent act or a crime." Hence, protections against self-incrimination due to mental health were established early so that systemic screening contemplated by the Indiana Project could in fact occur. The success the ISBA enjoyed legislatively resulted in large part due to the broad collaboration that the Indiana Project engendered.

Standardized protocols

Clear and consistent protocols for how mental health screening should be conducted allowing for the protection of confidentiality at the county sites were developed by the board, which enabled increased fidelity across county systems. Without predetermined protocols each county would have different operating procedures and would not necessarily implement the screening process with the entire population. Additionally, systematic differences in administration could affect the results of the screening process. Hence, these protocols make it possible to generalize knowledge gained from the screening project, while also specifying the threshold at which mental health services needed to be implemented. Per guidelines from the developers of the MAYSI-2, a youth is considered to have screened high on the MAYSI-2 if the score on the suicide ideation scale is in the caution or warning range, or if two or more subscales are in the warning range (Grisso & Barnum, 2001). However, if the county believes it is necessary, each county site is allowed to use a lower threshold to identify more at-risk youth. If a youth scores above the threshold, per that county's protocol, a mental health assessment is initiated. This process includes the detention facility contacting the parents/guardians, providing the summary results of the MAYSI-2 to families, and requesting consent for further assessment and evaluation. If consent is not granted, then facility staff has the option to obtain court-ordered treatment on a case-by-case basis in emergency situations.

The process for data collection was also standardized. Non-identified data is collected from each county pilot site on a monthly basis regarding how many youth have been screened, how many of those youth are out-of-county residents, and whether or not a second screening was administered at the detention center. Additionally, information is collected regarding contact with a mental health professional during detention and post-release, referrals for mental health services post-release, and whether or not those services both in detention and post-release were ordered by the court. Furthermore, data is collected for every screened youth exploring whether or not they were re-arrested at three, six and 12 months from the date of their release from detention. Recidivism data for all screened youth informs the project as to the effectiveness of the screening, referral and connection-to-services process.

Lastly, each county has a "steering committee" that reviews protocols, develops county-specific, data-sharing agreements, and adopts screening protocols that allows each county to collaborate with the Indiana Project. Although clear and consistent protocols have been developed for the project as a whole, each county is unique in that it has different resources, restrictions and operating procedures. It is important for the project to be

implemented according to protocol at each site. It is also important for each county site to implement the protocol without causing undue strain. The steering committee reviews the protocols and proposes any possible changes for its county to the State Advisory Board. This process not only tailors the project to each site, it also gives a sense of ownership that improves collaboration between each site and the state project.

Information sharing

In order to connect youth to care upon reentry, information sharing between the juvenile justice and mental health systems is essential. Hence, every effort has been made to ensure confidentiality of information gleaned during the screening process. The Indiana State Bar Association's role in the Indiana Project was crucial in this regard as its legal expertise provided guidance about how best to protect and ensure confidentiality in the implementation of the program. Clear guidelines were developed that governed how screening information was shared between sites and agencies, which ensured compliance with the Health Insurance Portability & Accountability Act (HIPAA) guidelines and the proper application of information gathered from the screening process. This was particularly important since there were multiple discussions and interpretations regarding how HIPAA applies to youth in juvenile justice. Counties were more willing to participate once the role of HIPAA on mental health screening and referral to treatment was delineated.

Limit barriers to mental health care upon community reentry

A second legislative effort resulted in passage of Indiana House Bill 1536, effective July 2009, in an effort to promote connection to care for court-involved juveniles. Federal Medicaid law prohibits participation "with respect to care or services for any individual who is an inmate of a public institution [except as a patient in a medical institution; 42 C.F.R 441.33 (a)(1), 435.1008(a)(1)]." A. E. Cuellar and colleagues (Cuellar, Kelleher, Rolls & Pajer, 2005) showed that there is substantial confusion about this policy among individuals employed in the juvenile justice system and those employed by state Medicaid programs. Specifically, most states continue to terminate, rather than suspend, Medicaid coverage upon incarceration. Termination of Medicaid coverage is especially problematic for youth who already receive services or for those with relatively acute needs (due to the wait time for re-enrollment of 45 to 90 days) (Koppelman, 2005). Hence, efforts to amend this practice within Indiana were initiated to better enable connection to mental health care upon release from detention and short stays in correctional facilities. The bill states that if a juvenile Medicaid recipient is placed in a juvenile detention facility or a secure facility, his or her Medicaid eligibility shall be suspended for up to six months before it can be terminated. Termination of Medicaid eligibility for incoming inmates was standard procedure before the passage of this bill, thus creating another barrier for juveniles in need of services upon release. Now, if a youth is a Medicaid recipient before entry into a juvenile detention center, his or her Medicaid status is merely suspended during incarceration. When youth are referred for further evaluation or treatment post-release, they are not denied services due to termination of coverage.

Effects of systematic mental health screening in Indiana

As a result of the Indiana Project, more than 18,500 mental health screens have been conducted on youth entering detention in Indiana since 2008. If the youth is above the cutoff score, the seriousness of his or her symptoms is considered "clinically significant," that is, high enough to require some form of follow-up response. In 2008, pilot sites conducted 5,771 mental health screens; 25.7 percent of youth screened scored above the cutoff requiring a response. Of those screened, 2,472 were African American, 580 were Hispanic, and 128 were "other." In 2009, pilot sites conducted 6,195 mental health screens; 20.4 percent of youth screened scored above the cutoff. Of those screened, 2,618 were African American, 570 were Hispanic, and 150 were "other." From Jan. 1 to April 30, 2010, 2,061 screens were conducted by the pilot sites; 21 percent scored above the cutoff. Of those screened, 855 were African American, 188 were Hispanic, and 41 were "other."

The racial demographic breakdown for youth in the participating pilot sites in the first two years of the project is as follows:

	2008	2009
African American	42.7%	42.2%
Caucasian	44.8%	46.1%
Hispanic	10.0%	9.2%
Other	2.5%	2.4%

Research has shown that minority youth evidence disparity in connection to appropriate mental health care. White youth and females in the justice system are diagnosed with mental illness more frequently, and they are more likely to receive treatment once diagnosed (Herz, 2001; Pope, Lovell & Hsia, 2002; Abram, Paskar, Washburn & Teplin, 2008; Teplin, Abram, McClelland, Washburn & Pikus, 2005; Lopez-Williams, Stoep, Kuo & Stewart, 2006). In one study, race was the only significant predictor of receiving treatment with white youth being more likely to receive treatment than black youth (Shelton, 2005). Even in studies where the level of disturbance is considered, white youths are disproportionately more likely to receive treatment in detention (Glisson, 1996; Thomas & Stubbe, 1996).

Connection to mental health care

A goal of the Juvenile Mental Health Screening, Assessment & Treatment Project has not only been to conduct mental health screening for youth to improve outcomes during the detention stay but also to connect youth to needed mental health care upon community reentry.

Effective treatments exist for mental health problems among youth in the juvenile justice system. For instance, multi-systemic therapy and wraparound services for juvenile justice and other youth with significant emotional difficulties have been shown to reduce recidivism (Anderson *et al.*, 2003; Burns *et al.*, 2000; Henggeler *et al.*, 2003). The state of Vermont, in a study of

recidivism predictors, found that juvenile incarceration rates were negatively related to the utilization of public mental health services (State Department of Developmental & Mental Health Services, Vermont Mental Health Performance Indicator Project). Mental health problems that are untreated tend to be strong predictors of recidivism (Vermeiren, 2003). Although inadequately studied, providing linkages to care during and following detention may substantially lower recidivism (Gupta *et al.,* 2005).

Very little research has been conducted to evaluate the effectiveness of making connections to care after release. Through a separate Juvenile Accountability Block Grant (titled "Connection to Care Project"), which concluded in April 2010, Dr. Matthew C. Aalsma conducted a research study on connection to mental health care for detained youth using four of the original pilot sites in the Juvenile Mental Health Screening, Assessment & Treatment Project. The goal of this study was to explore the perceptions of youth (who scored high on the mental health screening measure) and their parents in accessing mental health care. The most often listed issues described by participants that impacted connection to mental health care included the following: cost of care/insurance; probation officer and family members as facilitators to care; and mental health stigma. Parents who did not have insurance or who had private insurance described paying significant amounts to facilitate mental health care utilization. Parents who did have Medicaid as their youth's insurance, or some variation of federally funded insurance, had the majority of the mental health care covered. The results showed a need for both individual/family as well as juvenile justice system-wide intervention.

The next step to the identified problems in connection to care is the development of a model to effect system-wide intervention, providing assistance and information at crucial points in the reentry process to improve the ability and motivation of youth identified through mental health screening to actually follow up and connect with mental health care.

Conclusion

Currently, 16 out of 22 detention centers and one intake center in the state are participating in the Indiana Project. Our pilot sites are Lake, Marion, Bartholomew, Johnson, Porter, Clark, Grant, Delaware, LaPorte, Howard, Tippecanoe, Hamilton, Henry, Dearborn, Elkhart, Knox and Vigo counties. As a result of the pilot project, by January of 2011, more than 18,500 mental health screens had been conducted on youth entering detention in Indiana.

Plans for the future include continuing to recruit additional pilot sites on a rolling basis and to incorporate these sites into the project. Results of the pilot project will be published as data are received. Published results will continue to inform the State Advisory Board with recommendations for project implementation. In order to ensure the project's permanence, efforts will be made to secure long-term funding sources.

A major, unique feature of the Indiana Project includes partnering with the ISBA, which led to specific legislation, protecting adjudicated youth who participate in the screening process, as well as eliminating a potential obstacle to obtaining care. The Indiana Project has a diverse group of stakeholders that have worked together during all phases of the project. This diverse, cross-disciplinary approach has been essential to its success. This approach has allowed the project to take into consideration the state's unique political landscape and existing organizational infrastructure as the project was implemented. In particular, when seeking to impact the public health of individuals within the criminal justice system, building cross-system collaborations with nontraditional public health allies, such as bar associations and other professional organizations, will allow for increased cooperation in order to improve public health efforts. Additionally, cross-system and disciplinary partnerships are necessary in order to amend state policies that may impede screening and connection to mental health care. •

Reference List

Cauffman, E. (2004). "A Statewide Screening of Mental Health Symptoms Among Juvenile Offenders in Detention," *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 430-439.

Cuellar, A. E., Kelleher, K. J., Rolls, J. A., & Pajer, K. (2005). "Public Health Consequences of Imprisonment | Medicaid Insurance Policy for Youths Involved in the Criminal Justice System," *American Journal of Public Health*, 95, 1707-1711.

Fazel, S., Doll, H., & Langstrom, N. (2008). "Mental Disorders Among Adolescents in Juvenile Detention and Correctional Facilities: A Systematic Review and Metaregression Analysis of 25 Surveys," *Journal of the American Academy of Child & Adolescent Psychiatry*, 47, 1010-1019.

Grisso, T., & Barnum, R. (2001). The Massachusetts Youth Screening Instrument: Second version (MAYSI-2). Worcester, MA: University of Massachusetts Medical School.

Grisso, T., Barnum, R., Fletcher, K. E., Cauffman, E., & Peuschold, D. (2001). "Massachusetts Youth Screening Instrument for Mental Health Needs of Juvenile Justice Youths," *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 541-548.

Koppelman, J. (2005). "Mental Health and Juvenile Justice: Moving Toward More Effective Systems of Care" (Issue Brief – No. 805). Washington, D.C., National Health Policy Forum.

Skowyra, K., & Powell, S. D. (2006). "Juvenile Diversion: Programs for Justice-Involved Youth with Mental Health Disorders," Research and Program Brief, National Center for Mental Health & Juvenile Justice.

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). "Psychiatric Disorders in Youth in Juvenile Detention," Archives, *General Psychiatry,* 59, 1133-1143.

Vermeiren, R. (2003). "Psychopathology and Delinquency in Adolescents: A Descriptive and Developmental Perspective," *Clinical Psychology Review,* 23, 277-318.

Williams, V. A., Grisso, T., Valentine, M., & Remsburg, M. (2008). "Mental Health Screening: Pennsylvania's Experience in Juvenile Detention," *Corrections Today,* 70, 24-27.

Recommendation 1

The Indiana Juvenile Mental Health Screening, Assessment & Treatment Project should be sustained and supported at the state level.

State-level support in sustaining the pilot project model would provide a means to address both the need to identify youth with mental health needs at an early intervention point and the need to connect those youth with appropriate mental health care. State-level systematization would continue, expand and sustain the routine mental health screening of youth entering detention; institute adherence to protocols that ensure confidentiality and treatment objectives of the screening process; and foster connection to care for youth identified through mental health screening. State governance should encourage the continued involvement of a broad collaborative as the pilot project transitions into a permanently supported service program for children at the point of detention.

• Employ a state-level independent governing board utilizing the diverse, collaborative composition of the pilot project's State Advisory Board as a model.[1]

- To help ensure both sustainability and independence of the project, the administrative functions should be assigned to an outside nongovernmental agency, with program oversight and financial support provided through judicial branch administration.
- University analysis of the data is an important aspect of the project from a research perspective to move forward and link data to outcomes. Therefore, the project should continue to utilize university participation for support with data gathering and technical assistance.

• Through the creation and use of incentives, promote the participation of all facilities that securely detain youth in Indiana, so that a uniform screening tool is consistently used, participation in statewide data collection is assured, and protections of project protocols are afforded to youth.

• Pursue legislation or rule change to require the use of a specific mental health screening tool and collection of data at all detention facilities in the state, even for those not participating in the project, so that statewide prevalence data is consistently available.

• Consideration should be given in the long term to expanding the project beyond detention, to youth at intake so that all youth coming in contact with the juvenile justice system are screened for mental health issues.

• There should be state-level coordination and linkage of juvenile justice issues and initiatives in a manner that integrates in and benefits from the continuing work of the mental health pilot project.

Recommendation 2

Electronic database case management systems should be made consistent and compatible throughout the state of Indiana.

An important issue that has arisen through the Indiana Juvenile Mental Health Screening, Assessment & Treatment Project is the lack of uniformity across electronic database management systems in Indiana. Some counties utilize paper and pencil records, others use QUEST, and others use Odyssey. This has resulted in difficulty in measuring recidivism, assessing detention center practices for follow-up of youth who screen positive on the mental health screen, and understanding if youth connect with mental health care upon community reentry. Ensuring that all counties use databases that are consistent and compatible will allow sound data to be collected, as well as uniform follow-up of youth across the state and across systems (juvenile justice, child welfare, corrections).

• Create incentives and funding options for resource-poor detention centers to implement electronic database management systems.

• Assure uniformity in data and in reporting by having already instituted electronic database management systems use consistent definitions of variables.

• Consider the creation of a statewide data repository to ensure data uniformity. This data repository could be utilized not only for the Indiana Juvenile Mental Health Screening, Assessment & Treatment Project but also for other relevant statewide initiatives (*e.g.,* Juvenile Detention Alternatives Initiative; Disproportionate Minority Contact).

Recommendation 3

Gaps and/or barriers to identifying youth with mental health needs and connecting identified youth to appropriate mental health services must be identified and addressed.

In addressing mental health needs of youth in the juvenile justice system, counties face serious obstacles to identifying youth and connecting them to care. Gaps and barriers to identification, assessment and treatment exist at critical points in the juvenile justice system process, including at diversion, detention and release. Once children are identified, there are several barriers to care, including a lack of available community-based mental health services for treatment; a lack of insurance coverage, preventing children from receiving needed care and treatment; difficulties arising from the approval process for the payment of services through government agencies responsible for such payments; lack of training for working with youth with mental health needs on the part of caregivers, law enforcement and detention workers; and the great amount of variation in the availability and types of services, detention practices and probation policies across the state.

• Gaps and barriers should be identified, and state officials and agencies should work in partnership with local communities to invest in addressing these obstacles through development of appropriate resources in all systems of care, so as to create continuous care for all youth.

• Standardization of response systems for youth with mental health needs should be developed through efforts of professional associations and oversight entities.

• Training should be developed based on emerging best practices of those working with and caring for youth with mental health needs.

• Best practices to respond to youth identified with mental health needs across systems should be implemented and extended beyond detention to other areas, such as first response, diversion, arrest, probation, detention, incarceration and reentry.

Recommendation 4

Viable options for funding the ongoing work of the Indiana Juvenile Mental Health Screening, Assessment & Treatment Project should be created through the state's general budget allocation, with a focus on ongoing, long-term financial support for the administrative and oversight functions of the project, and through the development of state and local funding options that support increased access to mental health care for youth in detention.

State-level financial support should be provided in order to sustain the pilot project's continued development over time and underwrite administrative costs of program oversight and data collection. Both state and local funding are needed to support increased access to care through timely access to treatment and case management of youth in local programs (including diverted youth).

• Identify sources for state-level support of the pilot project, including examination of dedicated funds.

• Consider funding programs with awards to counties based on a statewide formula through use of a model such as the GAL/CASA model or LCC model.[2]

• Develop alternative local funding options and financial incentive programs. •

1. The pilot project is guided and directed by the State Advisory Board, which was created through identifying and assembling key stakeholders of collaborating, cross-disciplinary agencies and organizations. The State Advisory Board includes representatives from the Indiana Judicial Center Juvenile Justice Improvement Committee, Indiana Criminal Justice Institute, Indiana Prosecuting Attorneys Council, Indiana Public Defender Council, Indiana Division of Mental Health & Addiction, Indiana Juvenile Detention Association, Indiana Minority Health Coalition, ISBA Civil Rights of Children Committee, Indiana Chapter of the American Academy of Pediatrics, Indiana University School of Medicine, Probation Officers Professional Association of Indiana, Indiana Department of Child Services, Indiana Department of Correction, Indiana Department of Education, and Indiana Council of Community Mental Health Centers. In addition to these representatives, a representative from each of the pilot site counties and three members of the Indiana General Assembly serve on the State Advisory Board.
2. I.C. §5-2-11. The Governor's Commission for a Drug-Free Indiana works in a collaborative capacity with 92 local coordinating councils (LCCs) representing each of Indiana's counties.

Indiana Juvenile Mental Health Screening, Assessment & Treatment Project Advisory Board

Hon. Mary Harper, Valparaiso, chair; JauNae Hanger, Indianapolis, vice chair; Laurie Elliott, Indianapolis, project director; Amy Karozos, Indianapolis; Matthew Aalsma, Ph.D., Indianapolis; Traci Agner, Lawrenceburg; Ashley Barnett, Indianapolis; Margaret Blythe, M.D., Indianapolis; Hon. Mary Beth Bonaventura, Crown Point; Becky Bowman, Indianapolis; Jason Bowser, Columbus; Bob Bragg, Noblesville; Matthew Brooks, Indianapolis; Rep. Charlie Brown, Indianapolis; Kristi Bruther, Franklin; Hon. Vicki Carmichael, Jeffersonville; Arthur Carter, Indianapolis; Hon. Steve David, Whitestown; David Dickerson, Muncie; Hon. Nancy Gettinger, LaPorte; Jim Higdon, Franklin; Steve Johnson, Indianapolis; Larry Landis, Indianapolis; Sen. Connie Lawson, Indianapolis; Tanya Johnson, Indianapolis; Sue Lummus, Indianapolis; Tracey Malone, Kokomo; Mary McAteer, M.D., Carmel; Kellie Meyer, Indianapolis; Hon. Marilyn Moores, Indianapolis; David Orentlicher, Indianapolis; James Payne, Indianapolis; Mike Small, Marion; Hon. Paulette Stagg, Terre Haute; April Vanlonden, Richmond; Kellie Whitcomb, Indianapolis; Hon. Mary Willis, New Castle; and Jenny Young, Indianapolis.

Editor's Note: The above list does not yet include representatives from the three newest project sites of Elkhart, Vigo and Knox counties.