Providing Comprehensive Health Care to Court-Involved Youth:

A Resource Guide for Community Health and Social Service Providers

Health & Medicine
POLICY RESEARCH GROUP

Contents

About Health & Medicine Policy Research Group

Health & Medicine is a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity. Founded in 1981 by Dr. Quentin Young, it was formed as an action-oriented policy center—nimble, independent, and focused on regional health issues. Health & Medicine's mission is to promote social justice and challenge inequities in health and healthcare. It conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people. Health & Medicine has successfully developed health policy recommendations and implementation strategies for different public and private entities, earning the trust of the legislature, advocates, the media, researchers, and policymakers at all levels of government in Illinois to become the region's "honest broker" on health care policy matters. Learn more at www.hmprg.org.

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Introduction

Court-involved youth (CIY) are some of the most marginalized and vulnerable young people in our community. In addition to over-representation in the juvenile court system, youth who experience economic inequity, youth of color, those with disabilities and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) youth are also over-represented in the child welfare system. CIY are navigating the nexus of community divestment, disproportionate incarceration of family members and acquaintances, and discrimination which increase their likelihood of having direct contact with the criminal justice system.

Many young people in the court system have histories of trauma, and data suggests that the experience of incarceration itself is traumatic in a number of ways. For example, many youth experience isolation due to being detained in remote facilities, making contact with loved ones a challenge. Youth in the juvenile justice system are often housed in understaffed and under-resourced facilities and experience institutionalized forms of violence that compound their experience of trauma.

Additionally, certain populations within the juvenile justice system are particularly vulnerable. For example, girls' rate of sexual abuse is four times higher than boys' and girls' rate of complex trauma is nearly twice as high. LGBTQ youth are 12 times more likely to experience sexual assault while detained at a juvenile facility than their heterosexual-identifying peers. LGBTQ youth are also 16 times more likely to attempt suicide than their straight counterparts.

How to Use This Resource Guide

Though this guide was drafted to support healthcare providers in delivering care to a specific youth population—court-involved youth—we believe that it can also be of value to others. As a reader, if you or your organization serves individuals from marginalized groups, we hope you will find much information that is applicable to your work. We also ask that you share this guide with fellow practitioners and colleagues—if you find it to be useful, we hope others will as well. It is our goal for this resource guide to serve as a springboard for conversations that can help develop solutions to support overlooked communities.

We also welcome any feedback you may have. Simply email us at info@hmprg.org or call us at 312-372-4292.

Exacerbating these conditions are the vast intersecting issues that affect these young people's day-to-day lives, limiting opportunities for self-agency. Under such circumstances, health care is often not viewed as an immediate priority.

What the Data Shows: A Snapshot of Chicago's Court-Involved Youth

Economic Inequity

Court-involved youth often come from Chicago's most under-resourced communities. The communities that the largest numbers of youth are returning to following their detainment are Auburn Gresham, Pullman, North and South Lawndale, Austin, and West Garfield Park.[1] These communities experience persistent poverty, meaning that at least 20% of households have been in poverty for two decades.[2] These economic factors are directly linked to health outcomes. For instance, the life expectancy for a person living in Garfield Park is 69 years, compared with a life expectancy of 85 years for a resident of Chicago's Loop.[3]

Racial and Ethnic Disparities

In the last 10 years, the rate of youth entering the juvenile system has decreased by 41%. However, racial disparities in the juvenile justice system have not improved, increasing by 15%.[4] Though they only represent

29% of Cook County's youth population, Black young people accounted for 73% of juvenile arrest, 85% of youth detained, 87% of those sent to a residential placement, and 88% transferred to adult court in 2013. Similarly, Latinx youth represent 34% of Cook County's youth, 12 % of youth detained, 18% of those sent to a residential placement, and 10% of youth transferred to adult court.[5]

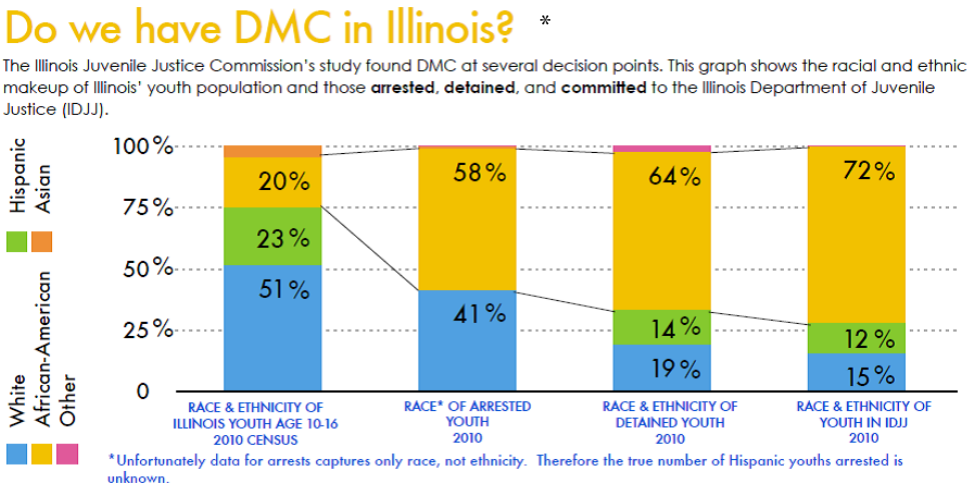
Gender and Court-Involved Youth

Boy/Male-Identified Youth

Boys' experience of being institutionalized make them vulnerable to higher incidences of victimization while incarcerated. Boys are also at risk of repeating much of the dominant and violent forms of masculinity that are expressed in such settings and thereby victimizing others. In Illinois, 66% of boys at the detention stage met the criteria for at least one psychiatric disorder and 46% of boys had more than one disorder.[6]

Girl/Female-Identified Youth

Although youth who identify as boys comprise the majority of youth in the criminal justice system, girls have been incarcerated at alarming rates over the past 25 years.[7] Girls, like women, are being jailed in greater numbers than at any other point in history. Black girls, like Black women, are disproportionately overrepresented in the criminal justice system. Girls' rate of sexual abuse is four times higher than incarcerated boys' and their rate of complex trauma is nearly twice as high.[8] In Illinois, 75% of girls at the detention stage met the criteria for at least one psychiatric disorder and over 56% of girls had more than one disorder.[9] Additionally, a 2007 study by Gallagher, et al found that nationally 2.1 % of incarcerated girls are pregnant and receive limited, if any, prenatal care.[10]



Source: Illinois Juvenile Justice Commission, Highlights from the Assessment of Racial and Ethnic Disparities in Illinois' Juvenile Justice System

**Disproportionate Minority Contact*

LGBTQ Youth

LGBTQ youth also are overrepresented in the juvenile justice system. Research has shown that up to 20% of court-involved youth identify as members of the LGBTQ community.[11] LGBTQ youth are more likely to face homelessness, be arrested and detained for status/age-related offenses, nonviolent offenses, and are at higher risk for drug use.[12,13, 14] LGBTQ youth are also twice as likely to be jailed before adjudication for nonviolent offenses.[15] When jailed, LGBTQ youth are 12 times more likely to experience sexual assault inside a juvenile facility than their peers.[16] Furthermore, LGBTQ youth are especially vulnerable to violence in institutionalized settings that do not understand the spectrum of sexual and gender identity.

Immigrant and Refugee Youth

The mass targeting, separation, and deportation of immigrants and refugees has given rise to fear, anxiety, and distrust of U.S. institutions, including the health care system.[17] Court-involved immigrant and/or refugee youth and their families are especially vulnerable. Undocumented youth are brought to the attention of Immigration and Customs Enforcement (ICE) via the juvenile justice system without clear legal status.[18] As a

result, approximately 1,000 minors are transferred to immigration detainment facilities annually through internal enforcement efforts by ICE.[19] Research from Mental Health America suggests these chronic and increasing stressors—like fear of deportation, discrimination, or violence—can have negative physical and mental health effects.

Youth with Disabilities

Though the population is rarely mentioned, 65 to 70% of youth that are court-involved have a disability.[20] Approximately 90% of court-involved disabled youth have experienced a traumatic event, 70% meet criteria to be diagnosed with a mental health condition, and 30% meet criteria to be diagnosed with post-traumatic stress disorder (PTSD).[21]

Source: ColorLines, Infographic: From Disability to Criminality

With the advent of zero-tolerance policies in public and charter education, we have seen an increase in youth becoming involved in the juvenile justice system directly from their schools of attendance. There is overwhelming data that suggests students with emotional or behavioral disorders or learning disabilities are arrested and incarcerated at a higher rate than their peers without disabilities. Such outcomes are due in part to a lack of training in how to positively engage and discipline students with developmental disabilities and/or behavioral challenges.[22] School closings can exacerbate this due to the impact of limited services; an increase in vacancies of trained special education teachers, lack of clinical services, overcrowded classrooms, and decreased funding to meet the increase of enrolled students, all of which disproportionately impact youth with disabilities. [23] Even with a diagnosis, court-involved youth with disabilities have conditions and overall health that worsen under harsh environments and without proper continuity of care.

Learning from the Community

Centering our work on the five zip codes youth most frequently return home to after being incarcerated, Health & Medicine's Court-Involved Youth Project brought together youth, community-based providers, and juvenile justice staff to learn more about the complex needs of youth, to network, and to identify opportunities for partnership. In 2016, the Project held a number of focus groups to identify key barriers that justice-involved youth face when accessing health care.

Key Youth-Identified Barrier to Care: *Access*

- Youth may not have access to transportation or feel safe when traveling to appointments
- For families navigating chronic stressors, attending appointments is often an insurmountable challenge
- There may be a disconnection between youth and their families which could delay youths' health-seeking behaviors, especially when parental consent is required

- Youth may live with extended family who cannot consent to treatment
- Youth need privacy to talk to their doctors without their family members present, but may not feel comfortable asking for this privacy
- Youth, especially gender and sexual minorities and youth from faith-based families, may not feel comfortable talking to their parents/guardians about their comprehensive healthcare needs
- There is a lack of psychiatric care and care for people with severe mental illness
- There is a lack of access to comprehensive and coordinated resources for youth; there is a major lack of trauma-informed care, gender-responsive care, mental health services, and LGBTQ-affirming health care in the five zip codes studied by Health & Medicine
- Due to lack of funding and perceived lack of safety in under-resourced communities, community centers are reducing hours, closing earlier, or decreasing services, limiting access for youth and their families

Key Youth-Identified Barrier to Care: *Trust*

- Youth worry that having a warrant or other legal troubles will lead to their arrest if they access healthcare
- Youth, like court-involved adults, often worry about having to encounter social workers and police when entering clinics and hospitals
- Young people worry about the confidentiality of their health care services
- Youth have histories of trauma and distrust health care providers and other adults who make them feel scared and disempowered
- Young people worry that they might be manipulated, pressured, or forced to receive certain forms of care or will not receive certain forms of quality care, like reproductive health services
- Young women report not feeling safe with male doctors, particularly for sexual health issues
- Youth report feeling judged, pressured, or treated poorly by their providers and treated like they are "crazy" and "criminal"
- Youth are often dealing with past health care traumas that cause them to disengage from unresponsive care providers
- Youth and families from communities that have been historically exploited or mistreated by the medical and scientific establishment view clinics and hospitals with suspicion
- Incarcerated youth reported that they mistrust providers and do not believe that the materials providers use are clean or sterile
- Youth and their families do not always know, and have not been told, of their rights in consenting to and receiving healthcare
- Youth may not feel comfortable talking to their parents/guardians about their healthcare needs

Key Provider-Identified Barriers to Care: *Lack of Funding and Collaboration*

- Systems are concerned about making referrals for fear that they will lose that client to other providers
- Providers find it difficult to collaborate due to mistrust
- When funding is tied to the number of patients seen, comprehensive care is hard to provide
- Specific funder deliverables limit innovation
- Provider funding may be tied to populations or interventions that do not match the priorities of the individual provider or young person

Opportunities: Understanding the Unique Healthcare Needs of Court-Involved Youth

Justice-involved youth often have little access to preventive care within their neighborhoods. Given the importance of preventive care, the connections between mental health and physical health, and the role that primary care can play in supporting the overall well-being of patients and their families, Health & Medicine has worked to understand how to build and strengthen connections between the juvenile justice system and the mental and physical healthcare providers serving the communities to which Chicago's court-involved youth are returning.

It is important to remember that youth involved in the criminal justice system, like most youth, do not maintain routine medical visits and rarely seek preventive care on their own. The additional life course disruption of court involvement means that, according to the American Correctional Association, CIY have a disproportionate number of:

- Illnesses or diagnoses that should have been addressed in early childhood
- Immunizations that are not current
- Sexual and reproductive health needs that are unmet
- Appropriate health screenings that are not completed

Many youth receive basic health services for the first time when they are processed into the juvenile justice system. While youth often have access to basic physical and mental health interventions while in custody, poor care coordination means that these interventions do not follow young people when they leave the system, presenting unique challenges for community healthcare providers.

Understanding the unique context of court-involved youth's experience is essential to addressing their health needs upon release. Yet the majority of community providers treating these young people do not work in facilities that utilize trauma-informed models of care, have adequate mental and behavioral health services, or have affirming policies in place that reflect youths' unique experiences.

By understanding the needs and experiences of court-involved youth, there is great potential to improve healthcare for justice-involved youth—keeping them healthy and thriving in the communities—and thereby create stronger, healthier communities for all residents.

What Our Work Shows

Health and Medicine's Court-Involved Youth Project's Community Healthcare Initiative has focused on building connections between the juvenile justice system, community-based health providers, and local communities. We initially began by inventorying community-based resources from the five zip codes that youth most frequently return to from incarceration but have since expanded our work to include resources citywide.

Through collaboration with community partners, we developed the online resource probationcommunityresources.org, which houses information on over 500 resources throughout Chicago. After a close examination of our current database, we learned that although there are 316 youth-welcoming resources in Chicago, only 77 (about 15%) are located in the five zip codes that are most critical for youth who need health care upon returning to their communities.

Snapshot of Current Community-Based Health Services for Youth in Chicago*

Youth Health Services	Auburn Gresham 60620	South/ North Lawndale 60623	West Garfield Park 60624	Pullman 60628	Austin 60644	Citywide
Youth Accepting**	11	29	12	17	77	316
Mental Health	2	7	6	8	17	232
Substance Abuse	3	5	6	11	14	219
Reproductive & Sexual Health	0	9	2	5	6	22
Trauma-Informed***	0	1	2	1	1	47
LQBTQ Affirming****	0	1	2	4	1	8
Gender-Responsive*****	0	0	0	0	0	8

**Data is taken from a sampling of 500 resources surveyed in Summer 2017 version of Community Resource Database*
***Youth accepting is defined as any resource that accepts youth patients. Some are youth only and some accept adult and youth clients.*
**** The majority of Trauma-Informed resources were drawn from the Illinois ACEs Response Collaborative Environmental Scan*
*****LQBTQ affirming resources were included if they identified as such or were located on QUEERY*
******Health & Medicine defined gender-responsive resources as those who were trauma-informed, provided sexual and reproductive health, and were LGBTQ affirming*

What We Can Do: Best Practices and Solutions for Providing Comprehensive, Youth-Affirming Health Care

All youth have a host of intersecting experiences that require providers, clinics, health systems, and policymakers to be responsive to their unique and interrelated needs. Providing informed, high-quality, comprehensive, youth-centered, culturally-responsive, and empathic care should be the goal of all providers. The solutions identified below can help diverse stakeholders begin to move toward this goal.

Building Trust

Trust is the foundation of all reciprocal relationships and patient-centered relationships are no different. There is a considerable value in developing a patient-centered approach that delivers the kind of consistent, high-level service that is often lacking in marginalized communities.

Action Steps

- Create a training video discussing what families can expect during their visit that can be played while they wait for services.
- Develop a confidentiality mission statement that details the rights of parents and children and how such policies support young peoples' well-being. These policies should be given to parents and youth in preparation for their first visit.
- Screen parents and youth separately during the initial appointment. Completion of the Guidelines for Preventive Services (GAPS) Questionnaire, Adverse Childhood Experience (ACE) Questionnaire, Parenting Styles and Dimensions Questionnaire (PSDQ), Life Event Checklist (LEC), and a Family Needs Assessment can be used.

- Create assessment tools using the Institute of Medicine's Adolescent Health Services Delivery Recommendations, Substance Abuse and Mental Health Services Administration (SAMHSA) screening tools, and Motivational Interviewing guidelines as a template.
- Provide reading materials to explain the care and treatments that will be provided at the visit.
- Take a moment to answer questions prior to, during, and post-examination.
- Ask the young person if they have a preference for the gender of the provider they will see. Make it a priority to ask this question when the appointment is scheduled.
- Allow adequate time for appointments to ensure parents and youth feel supported and respected.
- Ensure reasonable accommodations and physical modifications to make facilities more accessible to people with disabilities.
- Draft documents for people with varying literacy levels.
- Allow security staff to wear civilian clothing and provide training so these staff will not be seen as a threat.

Creating a Trauma-Informed and Behavioral Health Inclusive Setting

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as experiences that are physically and/or emotionally harmful or life-threatening to ourselves or others, that overwhelm our ability to cope, and that have lasting adverse effects on our mental, physical, emotional, and spiritual well-being. A trauma-informed program, clinic, or system then is one that "realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization."[24] Trauma-informed services recognize that an individual's personal, social, and historical experiences may have caused trauma and may impact the way a person responds to stimuli, feels safe, accesses care, or remains in care. Additionally, they acknowledge that the experience of trauma impacts health and well-being throughout the lifespan.

One element of being a trauma-informed setting is providing access to integrated behavioral health services. The Chicago area has a lack of psychiatric care and care for people with a severe mental illness. As a result, individuals often face long wait times to access such services locally. Psychiatrists rarely take Medicaid and individuals with severe mental illness risk significant gaps in their medication management. In Illinois alone, per the 2015 Census, there were 1,029,580 adults living with mental illness.[25] During 2013-2014, approximately 105,000 of adolescents aged 12-17 had at least one major depressive episode, 61.8 % of whom did not receive treatment.[26] Maintenance of emotional health is not seen as an ongoing or chronic condition that needs continued treatment, and certain diagnosis lead to the continued criminalization of young people, particularly young people of color. As provider organizations try to move toward being trauma-informed, the following steps should be considered.

***Action Steps*[27]**

- Communicate about the trauma-informed transformation process.
- Train all staff—clinical and non-clinical—in trauma-informed practices.
- Engage patients in organizational planning.
- Create a safe physical and emotional environment.
- Implement the use of a trauma assessment or questionnaire as a part of the client intake process.
- Involve patients in the treatment process.
- Train staff in trauma-specific treatment approaches.
- Draft policies, procedures, and practices to respond to patient experiences of trauma.
- Provide therapeutic services via home visits and other evidence-based trauma-informed practices.
- Work with faith communities and other community-based services to educate on mental health and de-stigmatize mental illness.
- Use telepsychiatry.
- Make sure that there are warm handoffs to mental health providers in primary clinic and at the time of hospital release.
- Offer more psycho-social and afterschool activities as an entry point.
- Train primary care providers to manage low-tier mental illness.

Creating a Gender-Responsive Space

Agencies and providers that offer "gender-responsive" care consider gender, including issues of socialization, in order to provide culturally- and gender- relevant care. They also take into account the importance that gender may play in a patient's life. The following are steps organizations can take to make their care more gender-responsive.

Action Steps

- Implement the use of a trauma assessment or questionnaire as part of client intake.
- Develop gender-specific programming or interventions that empower and support gender minorities (girls, non-binary, gender fluid, and transgender youth) to be active agents in their health and lives.
- Have policies and/or written and posted practices that outline gender-responsive care and services.

Recognition of and Support for LGBTQ Clients

LGBTQ clients may have particular health care needs, and LGBTQ people often face discrimination when receiving medical care. Here are some steps providers can take to support these clients.

Action Steps

- Have policies and/or written and posted practices that outline gender-responsive and LGBTQ-affirming services.
- Implement comprehensive policies that prohibit discrimination on the basis of sexual orientation, gender identity, and gender expression to support both clients and staff.
- Create forms that collect information reflecting the diversity of gender identity, sexual orientation, and relationships.

Safe Space for Marginalized Communities

Individuals from marginalized communities, particularly immigrants, face many barriers when seeking care. The following are steps provider organizations can take to promote a welcoming environment for these populations.

Action Steps

- Have interpreters on staff to avoid violating HIPAA law by forcing non-English speaking clients to use family and friends as interpreters.
- Place abundant and clear signage in multiple languages to assure a welcoming institution.
- Provide medical and administrative staff resources on addressing the needs of marginalized patients and families.
- Establish a referral system for legal services, know your rights information, and other resources needed by immigrants and other marginalized communities.
- Clarify, revise, and strengthen policies and procedures that focus on protecting immigrant and marginalized patients.
- Identify and monitor indicators of neighborhood distress in immigrant and marginalized communities.
- Design and implement best practices for clinical and public health providers to deliver appropriate care.

Staff Training

Staff training provides an opportunity to expand the knowledge base of your workforce in order to improve their skills and protect them from undue stress and burnout. It is important to include direct care providers as well as administrative and support staff in trainings. Administrative staff engage with the community served prior to meeting medical or clinical personnel and are therefore critical in reflecting the values and norms of

your facility to those walking through the door for service. We recommend that staff should be trained in the following:

- **Motivational Interviewing** is a counseling method that helps people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes.
- **Trauma-informed care** refers to a program, organization, or system that realize the widespread impact of trauma and understands potential paths for recovery. A system that has adopted a culture of trauma-informed care recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system and responds by fully integrating knowledge about trauma into policies, procedures, and practices while seeking to actively resist re-traumatization.
- **Cultural competence** is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.[28] A cross-cultural framework recognizes the varied identities and necessary supports for groups such as people of color, marginalized religious affiliations, LGBTQ populations, and others.
- **Behavioral health and substance abuse warnings signs** as outlined by organizations such as the National Alliance on Mental Health (NAMI).
- **Immigrant Rights/Sanctuary Cities** and what resources are available for that population.

All paperwork, signage, audio, and visual resources should reflect that staff are trained in the areas listed above. From the moment clients walk through the door, they should be able to recognize that the clinic is a safe space, no matter the individual's circumstances of identity.

Chicago-Area Resources

Much of what seems insurmountable in serving populations with extensive barriers can be addressed by leveraging collaborative partnerships. Developing memorandums of understandings and jointly drafting and submitting funding proposals that expand the work of each organization, while reflecting community needs, can be a powerful impetus for change. Some specific youth-affirming organizations and potential partners in the Chicago-area include:

- The **Night Ministry** and **Mobile Care Chicago** work with youth where they are. A connection with these groups expands a clinic's ability to engage hard-to-reach youth in direct services and case management.
- The **Illinois Coalition for Immigrant and Refugee Rights (ICIRR)** provides immigration and Sanctuary City-based training to staff as well as collaborating to develop signage and other documents.
- The **Illinois Collaboration on Youth** works with institutions to provide employee trauma-based training, as do members of ACE Interface through the **Illinois ACEs Response Collaborative**.
- **Local post-secondary institutions** offer part-time employment for graduate-level students to provide case management services onsite and via home visiting which can help inform the community of the services that you provide.
- The **National Alliance on Mental Illness (NAMI) Chicago** provides mental health crisis training.

- The **Howard Brown Health Center** and the **Center on Halsted** can create LGBTQ-positive signage and distributable materials.
- **Chicago Public Schools** may be working to expand school-based health centers and train students attending secondary schools within your service area to act as youth health educators who can inform parents and youth alike about health services.
- **Local mental health agencies** such as the Cook County Health and Hospitals System (CCHHS) Mental Health Triage Center provide behavioral health services (as available) to clinic clients.
- **Local telepsychiatry practices** can be a partner in developing telepsychiatry initiatives.
- **SAMHSA** and **NAMI Chicago** provide a pathway for parents and youth to become Certified Recovery Support Specialists and/or Certified Family Partnership Professionals. This allows individuals with similar peer-based experiences to provide professional services and care within their communities.[29]

Policy Change: Lessons Learned From State Policy

In addition to our work with health and social service providers, juvenile justice system stakeholders, and youth, Health & Medicine's efforts have also sought to advance the necessary policy change to address structural barriers to health and help youth and communities thrive. While small "p" policy changes within local systems and agencies can have an important impact on the people served, large "P" policy at the federal, state, and local levels will build the foundation for addressing the health issues of court-involved youth via a systematic "upstream" approach. The following policies reflect efforts taken in Illinois and nationally which can help improve health at the large "P" level.

Illinois

SB 565, Public Act 99-0927

This act requires the Department of Public Health to develop rules and regulations around the examinations and procedures that constitute a health examination for children in Illinois and mandates that these encounters include an age-appropriate developmental screening and an age-appropriate social and emotional screening. It also requires that students present proof of having completed these screenings to their school at the beginning of the school year. Once the screenings are completed, the school may, with a parent's or guardian's consent, make appropriate school personnel available to work with the parent or guardian, the child, and the provider who signed the screening form to obtain any appropriate evaluations and services for the child.

HB 3502, Public Act 100-0184

This legislation establishes an Advisory Council on Early Identification and Treatment of Mental Health Conditions. The Council works to report and share information on evidence-based best practices related to early identification and treatment in Illinois and nationally; support providers to implement best practices, irrespective of payer such as Medicaid or private insurance; identify barriers to statewide implementation of early identification and treatment across all providers; and reduce the stigma of mental health conditions by treating them like any other medical condition. The act aims to "outline the path to enabling thousands of children, youth, and young adults in this State living with mental health conditions, including those related to trauma, to get the early diagnosis and treatment they need to effectively manage their condition and avoid potentially life-long debilitating symptoms."

Minnesota

Stat. § 245.4889. Children's Mental Health Grants

This statue enumerates services eligible for grants from the state related to training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and supports the development of an interactive website to share information and strategies to promote resilience and prevent trauma.

Oregon

Rev. Stat. § 414.629

This legislation outlines that Oregon community health improvement plans must be based on research, including research into adverse childhood experiences. Further, these plans must:

- Evaluate the adequacy of existing school-based health resources including school-based health centers and school nurses to meet the specific pediatric and adolescent health care needs in the community
- Make recommendations to improve the school-based health center and school nurse system
- Consider whether integration of school-based health centers with the larger health system or system of community clinics would further advance goals
- Improve integration of all services provided to meet the needs of children, adolescents, and families
- Focus on primary care, behavioral health, and oral health
- Address promotion of health and prevention and early intervention in the treatment of children and adolescents

Vermont

ACEs-related Legislation, 2014-15[30]

In 2014, the Vermont legislature passed a bill to require the Blueprint for Health (a state-led health care program that includes practices providing healthcare to the majority of Vermonters) to conduct a study addressing "whether, how, and to what extent" ACE-informed medical practice should be incorporated into Blueprint practices and community health teams. This study was based on legislation introduced by Dr. George Till **(H. 762)** that also included a provision to require Blueprint practices in the state to use the ACE questionnaire as a tool to assess health care. Only the study authorization was included in the final legislation **(S. 596, Act 144, signed by Governor on May 27, 2014).** As a result of that legislation, a report, "Integrating ACE-Informed Practice into the Blueprint for Health," was issued in January 2015.

In subsequent legislation **(H. 481, signed by the Governor on June 5, 2015, Vt. Act 54 of 2015, in Section 56.)**, the legislature directed the Blueprint for Health to "work collaboratively to begin including family-centered approaches and adverse childhood experience screenings consistent with the report entitled 'Integrating ACE-Informed Practice into the Blueprint for Health.' Considerations should include prevention, early identification, and screening, as well as reducing the impact of adverse childhood experiences through trauma-informed treatment and suicide prevention initiatives."

Recommended Resources

- **NAMI Chicago:** Mental Health Diversion Programs Best Practice Guide: Illinois Mental Health Opportunities for Youth Diversion Task Force

- **Shriver Center for Poverty Law:** Stemming the Tide: Diverting Youth With Mental Health Conditions from the Illinois Juvenile Justice System
- **Chicago Department of Public Health:** Chicago Healthy Adolescents & Teens
- **Illinois Caucus for Adolescent Health:** ICAH is a network of empowered youth and adult accomplices working to increase the capacity of school, family, and healthcare systems to support the sexual health, rights, and identities of youth.
- **Journal of Public Health Management and Practice:** From Theory to Practice: A 2-Year Demonstration of the Community-Centered Health Home Model
- **Probation Community Resources:** An interactive, searchable map to help criminal justice personnel refer clients to culturally-relevant and geographically-specific community-based services throughout the Chicago area
- **Chicago Foundation for Women:** Damage Done: The Impact of the Illinois Budget Stalemate on Women and Children
- **NAMI Chicago:** Resource Card
- **Center for Health Care Strategies, Inc.:** Laying the Groundwork for Trauma-Informed Care
- **The Arc National Center on Criminal Justice and Disability:** Justice-Involved Youth with Intellectual and Developmental Disabilities: A Call to Action for the Juvenile Justice Community
- **Juvenile Detention Alternatives Initiative:** Lesbian, Gay, Bisexual and Transgender Youth in the Juvenile Justice System
- **Children's Bureau:** The Adoption and Foster Care Analysis and Reporting System
- **Scarleteen:** Sex Ed for the Real World
- **Public Health Awakened:** Guide for Public Health Actions for Immigrant Rights
- **The CDC:** Disability and Health: Information for Health Care Providers
- **Chicago Youth Justice Data Project:** Infographic: Youth in the Juvenile Justice System
- **SAMHSA:** Trauma-related tools

Conclusion

Since 2014, Health & Medicine's Court-Involved Youth Project has worked to address the comprehensive health needs of youth returning to their communities from the juvenile justice system while expanding the capacities of the providers who serve them. Over the course of our project, we have worked to highlight the often under-utilized health resources in our community, fostered vital connections among providers, and worked to increase dialogue and policy change to better address the unique needs of justice-involved youth both within healthcare settings and the wider community. This resource guide represents a summary of key learnings from this work—capturing insights from both providers and youth. We hope that it helps the many organizations and systems dedicated to improving care for vulnerable young people to both begin and advance in their efforts to offer comprehensive, youth-affirming care. To that end, we welcome feedback on this resource guide. We also offer our thanks to the many young people, healthcare providers, and community-based organizations who shared their support and insight throughout this project.

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