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Helping Those Who Need It Most: Meeting the Mental Health Care Needs of Youth in the Foster Care and Juvenile Justice Systems

By Nell Bernstein

JUNE 2005

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Helping Those Who Need It Most: Meeting the Mental Health Care Needs of Youth in the Foster Care and Juvenile Justice Systems

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Nell Bernstein's writings have appeared in numerous national publications, including Glamour, Health, Legal Affairs, Marie Claire, Mother Jones, Newsday, O: The Oprah Magazine, Salon.com, Self, Redbook and the Washington Post. Her book, *All Alone in the World: Children of the Incarcerated*, will be published by The New Press in October 2005.

Bernstein has worked as a consultant to the California Research Bureau, conducting interviews with children of incarcerated parents, and exploring the mental health needs of young people in and exiting the foster care and juvenile justice system. In 2002, she was awarded a Journalism Fellowship in Child and Family Policy from the University of Maryland School of Journalism to report on the impact of Proposition 36 – California's drug treatment initiative – on children of addicted parents.

In May of 2000, Bernstein published *A Rage To Do Better: Listening to Young People from the Foster Care System*, a Pacific News Service report based on interviews with and surveys of youth currently and formerly in foster care and juvenile hall. Following the release of this report, she organized and moderated a day-long series of panels on foster care at the California State Legislature.

In January of that year, Bernstein was awarded a media fellowship from the Center on Crime, Communities and Culture of the Open Society Institute in New York. Her fellowship work focused on women prisoners and their children, and appeared in Salon.com, Motherjones.com, Redbook and The Industry Standard. She garnered the PASS Award from the National Center on Crime and Delinquency for this work. Bernstein also spent eight years as editor of YO! (Youth Outlook), a monthly magazine by and about young people produced by Pacific News Service.

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Introduction

Young people in this country who are in or transitioning out of the foster care and juvenile justice systems often have serious mental health needs. They can have many strikes against them: families with histories of violence, mental illness, incarceration and/or substance abuse; learning disabilities or neurological conditions; and histories of abuse, neglect or trauma. Some have been driven into the juvenile justice system, or onto the street, because of undiagnosed or inadequately treated psychiatric problems. These hard lives can result in mental health needs that the foster care and juvenile justice systems struggle to address, with limited success.

Whether because of inadequate resources, system flaws or mistrust and resistance from the youth themselves, young people in the foster care and juvenile justice systems are not getting the treatment they need to help them move into the adult world with the support, skills and resources they require in order to thrive.

Why do efforts to provide mental health services to these young people so often fall short? What can be done to improve the system? This journalistic report explores these questions and proposes some answers from young people who have experienced the system from the inside, and from practitioners who work with them. Over one hundred California young people who were in or had left the foster care and/or juvenile justice systems filled out written surveys. In addition, the author interviewed youth, mental health service providers and program directors.

The purpose of this report is to inform the legislature and state policymakers, the mental health and service-provider community, and the general public about the mental health needs of high-risk, transition-aged youth in the foster care and juvenile justice systems and about promising models and practices to meet their needs.

This report is divided into several sections. The first section provides an overview of the problem and its scope. It also addresses internal barriers to care, and includes recommendations from young people on ways the system could be reformed. The following sections are comprised of three case studies of programs that are using innovative approaches with positive results. Each case study includes a description of the program's practices in action, profiles of young people who have utilized the program's services, and lessons drawn. The remaining sections include Youth Voice – interviews with young people who have experienced mental health care in foster care or juvenile justice settings, and what they have to say about what worked for them, what didn't, and what might work better; and Expert Insight – perspectives and recommendations from professionals working in the field.

The report concludes with overall lessons that can be learned from this work. These are not easy answers; instead, they represent a framework for approaching the problem, and a place from which to begin.

No Easy Answers: Why Help Comes Hardest To Those Who Need it Most

Anyone who works with the most vulnerable youth – those in or transitioning out of the foster care and juvenile justice systems – will tell you that these young people often enter adulthood with overwhelming mental health needs. Those who aim to help them make a transition to adulthood and independence find an already-difficult task complicated – sometimes made virtually impossible – by the mental health issues these young people face.[*]

Young people themselves will tell you – in different words – virtually the same thing: They need help, counseling, support in their efforts to manage their turbulent inner worlds and establish themselves as adults. But they will tell you something else as well, over and over: If they have received mental health care, it did not help, or did not help enough.

Why have efforts to provide mental health services to these young people so often fallen short? It is not because the providers were incompetent or uncaring, but, often, because of the context in which care was provided: a system – be it group home, foster care agency, or juvenile hall – that the young people did not trust and by which they felt labeled and stigmatized.

"I can't sleep at night because of what I've been through when I was little," says Terrence (names have been changed), 18, who was abandoned for weeks at a time by his drug-abusing mother and went on to grow up in a series of foster and group homes. "The therapist at the group home gave me Paxil. Then I found out if you got a kid on medication, that's more money for the group home because it's 'higher risk.' When I found that out, I just refused to take it."

"I left school in the ninth grade," says Antonio, 23, who drifted from foster home to group home to juvenile hall while his mother cycled in and out of prison. "I was just depressed, and wondering what my life was going to be like. I was suicidal too, for a while. When I was in a group home, I climbed all the way on the roof and jumped off. Another time me and my friend tried to slit our wrists."

"I had counseling and therapy and all that" says Antonio, "but to me, that stuff doesn't work. It's like talking to a person who hears what I'm talking about but doesn't actually feel what I'm going through. If I'm going to be in counseling, it has to be a person who's been there, who knows. I feel that they're more real than a person who just reads it out of a book."

What might an alternative look like – a model in which young people could get the help they need without feeling labeled or misunderstood?

---

[*] For purposes of this report, transition-age youth are generally between ages 16 and 22.

The pages that follow represent an effort to address that question, through interviews with and written surveys of young people who have been through the foster care and juvenile justice systems, and profiles of California organizations that are piloting innovative approaches to meeting the mental health needs of young people in and emerging from these systems.

The Scope of the Problem: A Mental Health Crisis in the Juvenile and Foster Care Systems

Each year, more than a million young people nationwide come into contact with some facet of the juvenile justice system. As many as 80 percent have a diagnosable mental health disorder, and at least one in five has a serious emotional disturbance. Half or more, by some estimates, have co-occurring substance abuse disorders.

California offers no exception to this troubling national norm. The National Council on Crime and Delinquency (NCCD) reports that 42 percent of youth in detention have a mental health issue serious enough to require treatment or services.[1] Similarly, an assessment of the mental health system within the California Youth Authority (CYA) found that 65 percent of youth have serious symptoms of mental illness.[2]

A December 2003 report on mental health and substance abuse treatment services to youth in CYA facilities concluded that the youth authority "continues to fall short of meeting many recognized standards of care for youth with mental health and substance abuse disorders." Among the researchers' findings were that treatment plans were not devised or followed; medication was administered inconsistently or inappropriately, with some wards receiving as many as eight different medications; and practices such as the overuse of chemical restraints, near-solitary confinement in restrictive housing units, and keeping young wards in cages exacerbated the symptoms of mental illness.[3]

At the county level, NCCD researchers found mental health resources to be similarly inadequate. In 2003, the NCCD interviewed representatives of California probation and mental health departments. Almost two-thirds of probation departments, and the vast majority of mental health directors, reported that they did not have enough staff to handle the mental health needs of youth in the system.[4] Thirty of 45 counties reported they did not have appropriate services available for youth with mental health problems, and over half had no individual therapy available for young people in juvenile hall.[5]

Researcher Nancy M. Richardson looked closely at 34 juveniles from Fresno County who were committed to the Youth Authority in a half-year period during 2000. She interviewed 20 and reviewed multiple records for all 34. Richardson's review of wards' records reads like the index of the Diagnostic and Statistical Manual of Mental Disorders IV.[6] Her subjects had been variously diagnosed with coping deficit, paranoia, major depression, suicidal thoughts, suicide attempts, auditory hallucinations, acute stress disorder, psychotic disorder; mental instability, borderline personality disorder, schizophrenia, oppositional defiant disorder, attention deficit disorder, antisocial personality disorder, and impulse control disorder.[7]

While there is widespread agreement that youth with mental health problems should be diverted from juvenile institutions whenever possible, the reality is that young people with mental health problems stay on average nearly six times longer than others in the juvenile justice system. A national survey found that as many as 43 percent of parents of mentally ill youth felt their children had been placed in the juvenile justice system because needed services were not available in the community.

A consensus is emerging that the over-representation of mentally ill youth in the juvenile justice system reflects a broad failure to address mental health needs in the community. According to a 2000 report from the federal Department of Health and Human Services, one in ten American children suffers from mental illness severe enough to cause some level of impairment. Of these, only one in five receives mental health services. Too often, according to the report, "children who are not identified as having mental health problems and who do not receive services end up in jail. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low priorities for resources."[8]

When mentally ill youth land behind bars and continue to lack adequate or appropriate treatment, the consequences can be extreme. According to a study funded by the U.S. Office of Juvenile Justice and Delinquency Prevention, 11,000 young people engage in suicidal behavior in juvenile facilities each year.[9] In California, a recent juvenile detention profile identifies the rate of suicide attempts in juvenile halls as close to 24 per 1,000 youth in custody.[10]

Another 630,000 young people nationwide are in foster care on any given day;[11] one in five of them in California.[12] A recent study found that more than half the young people who leave foster care have one or more mental disorders; a quarter suffer from post-traumatic stress disorder.[13] One California study found that over three-quarters of teenagers in care needed a mental health referral.[14] Another study found that 15 percent of foster youth had attempted or contemplated suicide.[15]

That young people enter both the foster care and the juvenile justice system with a high rate of mental health problems should come as no surprise. An April 2003 report from the

JUVENILE DETAINEE SUICIDES IN CALIFORIA

In May 2003, 16-year-old Daniel Groth – a CYA ward with a history of suicide attempts – hung himself at the Northern Youth Correctional Reception Center and Clinic in Sacramento. In July 2003, 17-year-old Francis Ray –who had a history of psychological problems – hung himself in an isolation cell at the state prison at Tehachapi, which houses about 150 juveniles convicted as adults. Earlier that summer, two juveniles who were kept in isolation cells at the Los Angeles County Central Jail also attempted suicide. One of them had a documented history of mental illness. And, in January 2004, two juveniles were found hanged in their shared cell at Preston Youth Correctional Facility.

These suicides – combined with recent reports of dangerous conditions and inadequate mental health care at the California Youth Authority – make the mental health needs of California juveniles in detention a matter of particular urgency.

National Institute of Justice found a powerful correlation between youth victimization – including physical and sexual abuse; physically abusive punishments; and witnessing acts of violence – and subsequent mental health problems. Among boys who experienced sexual assault, for example, nearly thirty percent went on to develop post-traumatic stress disorder (PTSD). Many youth in the foster care system have experienced some form of victimization. Researchers estimate that over one fourth of those in the juvenile justice system have been abused. Nancy Richardson's review of wards from Fresno County found that 31 of the 34 youth had been the subject of referrals to Child Protective Services for abuse and neglect, many on multiple occasions.

HEIGHTENING THE HAZARDS

For a number of reasons, then, young people enter the juvenile justice and foster care systems with high rates of mental health problems. In too many cases, their experience within these systems exacerbates these problems – or contributes to new ones.

Within the juvenile justice system, young people who have experienced physical or sexual abuse may find themselves retraumatized by being physically restrained or searched. Psychologically vulnerable youth find themselves in the often-explosive company of others who are equally troubled. When conflict ensues, as it inevitably does, they may find themselves kept in isolation – a dangerous situation for a mentally unstable teenager. The researchers who studied mental health care in the CYA concluded that "the majority of youths who have mental health needs are made worse instead of improved by the correctional environment."[16]

Foster care brings its own mental health hazards. A review of the research on institutional care by the North American Council on Adoptable Children concluded that foster care increases the likelihood of psychiatric impairment, personality disorders and pervasive social dysfunction in adulthood. The number of placements in family foster homes has declined at least 25 percent over the past ten years, meaning that increasing numbers of young people will spend time in institutions instead – putting them at increased risk for mental health problems.

Young people who are placed in family foster homes often careen from one to the next, a scenario that can create or exacerbate attachment problems. In California, researchers determined that youth who experience five or more placements are more than six times as likely as those who stay in one home to receive mental health services for mood, behavior, psychotic, anxiety and adjustment disorders. Nearly a third of California's foster youth will experience five or more placements during their time in care. The result is a devastating cycle: children with emotional and behavioral problems are less likely than others to find a permanent home through either reunification or adoption,[17] and thus are more vulnerable to continued changes in placement and the related mental health consequences.

Compounding matters is the fact that many children spend time in both the foster care and juvenile justice systems. A comprehensive University of Chicago study of 732 teenagers in foster care found that 61 percent of boys and 41 percent of girls had been

arrested by the age of 17.[18] This large, and often overlooked, cohort of children – those who are veterans of two damaging systems – may be the most vulnerable of all.

INTERNAL BARRIERS TO CARE

The problem of providing mental health care to adolescents in and transitioning out of the foster care and juvenile justice systems is often described as one of inadequate resources. The question of resources is indeed an important one, but it is worth noting that in California, the majority of young people who emancipate from both the child welfare and the juvenile justice systems have received at least some mental health services. In fact, children in the child welfare system use mental health resources up to 15 times more than do other children in the Medicaid system.[19] Among the young people surveyed for this report,[20] 72 percent of those from the foster care system and 35 percent of those from the juvenile justice system had seen a therapist at some point. Thirty-five and 22 percent, respectively, had received medication, and 29 and 11 percent had at some point been in a psychiatric hospital. Among the 34 Fresno youth who Nancy Richardson studied, 21 had received mental health services while in juvenile hall.[21]

The question that matters most is not whether young people get services, but whether they get better. Young people's own perception of what has and has not helped them is only one measure of success, and certainly a subjective one. But when asked the question "What has most helped you maintain your mental health, however you define it?" the results are striking in their consistency. Only seven percent of our survey respondents from the foster care group, and one individual from the juvenile justice group, cited any kind of formal mental health intervention (therapy, medication, counseling, etc.) as being most helpful. The majority cited friends and family and/or themselves and their own capacities.

> "Thoughts. My thoughts on life." *Male, 18*

> "I have remained mentally healthy by reading books and family support." *Male, 19*

> "I would say my older sister she really motivates me. I try to follow in her footsteps because she is a strong independent woman who is working on her Masters." *Female, 24*

> "Looking at things down the road wanted that's hella important to me." *Male, 17*

> "Surviving!" *Male, 18*

The great majority of young people who were referred to mental health therapy during their time in the foster care or juvenile justice systems report that they were told or required to go by a representative of one of those systems – a judge, social worker, foster parent, group home provider or probation officer. At the same time, many young people assert that their experiences within the foster care and/or juvenile justice system had predisposed them to mistrust the adults who they associated with those systems – a mistrust that extended to mental health care providers.

> "In group homes, you're not really supposed to talk to the counselors. They don't support a lot of bonding. Plus, everyone there just reads your file and so it didn't matter what you told them. They were always prejudging me. Sometimes I tried to open up to counselors here and there and then they'd throw my file in my face. They'd say, 'Well, your file says….' Then I'd think I better tell them nothing, because they already knew what they thought of me." *Female, 22*

> One time I told my social worker that I seen a bottle of whiskey in my foster mother's drawer. I didn't know it was going in the report. I thought we were just having a regular private conversation.
>
> It drew a lot of friction. My foster mother came to me like, 'Why you going telling people lies?' I actually had to move.
>
> After that, I didn't say nothing to nobody. How's my day been? I ain't got nothing for you. I felt, 'Man, everything I say is going to go into a report, and I don't need that.'
>
> I had one therapist, but I didn't like her at all. I'm like, 'Lady, I don't know you. And you don't need to be knowing my business. You probably going to go off telling social workers and all that, putting stuff in my court papers. I'm cool – I'm not going to say nothing to you.' Then I'd just sit there on the couch and go to sleep."
> *Male, 18*

In their homes of origin, children may have been instructed to keep family business private. In the system, they have had the experience of everyone being "all in their business" in ways they see as damaging rather than helpful. In particular, they are haunted by the specter of "the file," which follows them everywhere, its (in their view) inaccurate and stigmatizing contents open to everyone but themselves. They make it a goal to do and say nothing that could contribute to what they perceive as a damaging and mysterious document.

In interviews, some young people spoke of being offered counseling and turning it down – or going briefly, never to return:

> "I was offered counseling when I was in foster care, but I didn't want it. I didn't know what happened in counseling. No one sat down and said, 'Hey, when you're having problems or issues, you can talk.' Just, 'Do you want counseling? No? OK.'
>
> I love counseling now. Me and my fiancé go to counseling. I want to become a counselor eventually. But back then I just thought it was someone asking me all these questions about things I don't want to talk about. And besides, 'I'm healthy – I don't need help anyway!' That was my mentality." *Female, 25*

Erika, 18, was referred to therapy repeatedly throughout her years in foster care. "As I got older," she recalls, "I didn't want to go, I guess 'cause they were always changing my therapist, and I always had a different social worker. So I wouldn't talk to the people 'cause I didn't trust them."

For young people who receive mental health care within the juvenile justice system, the coercive nature of that care can inspire profound mistrust. "In the Youth Authority, if they think you're too angry, they give you psychiatric medication," explained one young woman at a public forum on juvenile justice held by Pacific News Service in San Francisco. "If you don't take it, you can't come out of your room."

"I think they put sedatives in the food," she added. "I noticed that after I ate breakfast, I felt sleepy."

Others describe seeking mental health care within the juvenile justice system, only to be turned away because they did not meet the criteria. "When I was in juvenile hall, you had to fill out a grievance to talk to a mental health professional," recalled another young woman at the Pacific News Service forum. "Somebody came to see me two weeks later. She said they couldn't give me services because I wasn't diagnosed, and there were too many others who actually took medication. I just wanted to talk to someone, but she denied me because I wasn't taking meds."

Those who received and felt they had benefited from therapy were remarkably consistent in their evaluation of its value. To the question, "What was the best part about being in therapy?" the most popular response was some variant of "having someone to talk to."

> "Being able to talk to someone and not be judged." *Male, 18*
>
> "Letting out my frustrations and fears." *Female, 20*
>
> "Getting some weight off your shoulders by talking about things you can't usually talk about." *Male, 21*
>
> "Getting to be honest and talk about everything without worrying about what someone might think." *Male, 22*

But for many, "having someone to talk to" proved double-edged. In the context of their past and present experience, many young people experienced therapy as intrusive, a violation of their privacy – a concern that came up repeatedly in answer to the question, "What was the worst part of being in therapy?":

> "They get into details that sometimes you don't even want people to know about." *Female, 16*
>
> "The worst part was having to talk to someone who really didn't understand and wasn't familiar with your way of life." *Female, 18*
>
> "Them trying to make you tell them secrets." *Female, 18*

This anxiety around talking to strangers reflects a broader issue that many young people in both systems cited: the experience of having had their confidentiality breached, or the concern that it would be. This anxiety was also reflected in respondents' answers to the question, "What was the worst thing about being in therapy?"

"Wondering if they're going to tell all your business to your social worker or someone else." *Male, 21*

"I stopped seeing a therapist because she would go back and tell my grandmother everything I told her in what I thought was complete confidence." *Female, 20*

When researcher Lynne Marsenich conducted interviews with California mental health practitioners regarding the needs of foster youth, she found many harbored a similar concern: They were hesitant to treat foster youth because of "confidentiality concerns and the potential to negatively impact the therapeutic relationship."[22] Similarly, NCCD researchers report that staff at county mental health departments are apprehensive about evaluating young people in the juvenile justice system because they fear the results of their evaluation will be used against their young clients.[23]

When asked why and by whom they had been referred to therapy, many of our survey respondents gave answers that indicated a strong stigma associated with the referral.

"Because I'm a little off." *Female, 19*

"My mom and dad were dope fiends and I was taken from them. My worker said there was something wrong with me." *Male, 18*

"Teachers in elementary school, because I was acting crazy, I was told." *Male, 17*

Others believe that they were referred not because of their own particular needs but simply because of their status:

"Because everyone coming in foster care has to have a therapist." *Female, 18*

"It is part of their program. I was forced to go." *Female, 18*

"When I was caught stealing my probation requirements said I needed therapy." *Female, 18*

Several cited being forced to go as the worst thing about therapy, and – in answer to the question "What do you wish your therapist had done that he/she did not?" – expressed a desire to feel more in control of their own treatment:

"Give me an option to come or not to come.' *Female, 19*

"Let me decide what I needed." *Male, 16*

"Ask me if I needed help." *Male, 23*

YOUTH RECOMMENDATIONS ON SYSTEM REFORM: "IF I RAN THE SYSTEM"

Young people have much to say on the subject of the mental health care they have received, and the problems they have encountered in getting their needs met. But they also offer tremendous insight into solutions to the problems they describe – new ways of structuring the substance, delivery and even definition of mental health care that they would find not just acceptable but genuinely healing.

Perhaps the most surprising – and promising – survey finding was the response to the question "Do you consider yourself mentally healthy?" Nearly three-quarters of respondents answered "yes." Many elaborated, taking the question as an opportunity to inventory their strengths:

> "Yes, I don't allow negative thinking to hold me down." *Male, 18*
>
> "Yes, because I have the power to adapt to any situation." *Male, 18*
>
> "I consider myself very mentally stable because I can maintain in hectic situations." *Female, 18*
>
> "I find myself mentally hopeful. Hopeful that I have survived the unhealthy homes I was in." *Male, 23*

Given the diagnoses and histories of many of the surveyed youth, their overwhelming self-assessment as mentally healthy might well be viewed as denial. Another alternative is to view this as evidence of resilience, a tremendous resource and opportunity. System youth well know that the negative labels and expectations imposed on them can easily become self-fulfilling prophecies. But with the proper support and encouragement, young people's perception of themselves as healthy might achieve a similar self-fulfilling effect.

How might this be achieved? The programs profiled below offer one kind of road map: sustained interventions grounded in young people's own assessment of their needs and strengths.

Young people themselves offer a variety of potential routes to mental health. Survey respondents were asked to write essays on the following question: Imagine you are in charge. It is your job to support the "mental health" – whatever that means to you – of a young person who has been through hard times in his or her life. What would you do, say, offer or suggest?

Several important themes emerged from the imaginative and compassionate responses to this question.

Many emphasized the need to allow young people to participate in setting the agenda for their own mental health care, defining treatment goals:

> "I would first talk to the child. See if a therapist is something they want. I would make it optional. Unless there is a serious problem, then the child should know why he or she is going and explain to the child how it would help them. I didn't know why I was going. It didn't help me it only wasted my time. If someone explained to me how to make the best of my visit things might have been different. Also after the first visit ask the child how they liked the person, see if they felt comfortable and would like to come back. Forcing a child to talk about trauma is a hard thing to do, so they should have the option to talk with someone they felt safe with." *Female, 24*

> "I would first have them define mental health and give examples of mental health. Then I would ask them about their goals and where do they see themselves five years from now. If their response is positive I'll see how I can help and have them reach their goal and if it's negative, see some ways I can help them step by step. Before all the things I suggested I would first like to hear about their life story if they're willing to share, because based on my experience, we probably have similar stories." *Female, 20*

> "I would say to keep an open mind, because everyone is different with what they experience, and do not get controlling – it has provoked reluctance from a lot of people." *Female, 19*

> "Just to ask what they need and work on that." *Male, 23*

Young people stressed the importance of addressing survival needs as well as – or before – psychological concerns:

> "The most important rule to remember in social work is to start where the client is at. This means that you cannot have a set agenda of what needs to be worked on before you meet a client. If a client comes in off the streets who is hungry and needs a place to live, those issues are best addressed before any further therapy. My practice would use social work services and traditional psychotherapy as one unit of intervention to address the needs of the youth." *Female, 20*

Also echoing several of the service providers profiled below, a number of young people proposed taking mental health care out of the clinic and into less formal settings, where they might resemble a mentoring relationship:

> "Mental health would be more of a hang out with guidance. But not just therapy." *Female, 18*

> "Hobbies or something interesting to do, like art, so they don't have to think about bad more than good." *Male, 18*

> "First, I would ask the child to tell me about his life, so I can determine a way to be a positive role model for him. After that I would take him/her out to eat, play games and have fun so he/she could experience fun. And then I would always tell him/her to never give up, because there's always tomorrow. I would also tell him/her to keep

their head up and look around because someone is having it ten times harder." *Male, 17*

In keeping with recent research into youth development, respondents stressed the importance of emphasizing young people's strengths rather than simply their deficits or needs:

> "[I would tell someone] I know you went through a terrible time in your life. I know how you feel, because I was there. I'm here for you now. And I plan to be here for you for as long as I can. I have no intentions of ever hurting you or telling you something that isn't true or couldn't help you. I want to help you. But I need you to be open with me. I need you to be open to change and I need you to be open with yourself. I know what you've missed out on. And I know it hurts like hell to feel different and less important. But I want you to know that, to me and yourself, you are the most important person. You are different, but you're different with experience to overcome terrible things. You are different because you are strong." *Female, 20*

The need for consistent, compassionate and straightforward support was underlined repeatedly:

> "First of all, I would have to slow things down, let the youngster know somebody loves him so he has a true sense of security. Then I'd go from there, have her/him read books, take him on special events and so forth." *Male, 17*

> "If supporting mental health was my job I would let whoever I was working with know that I was there for them and I would do anything to support them. People who have been through hard times or have been just rejected because of the way they are need to know someone is there for them." *Female, 15*

> "I would become more of a friend to them, someone they could call any time of the day. I would just be a person that they could honestly call their best friend." Male, 20

> "To be a big brother or sister and offer my advice and people who might help so that me and the child could trust each other and that they could trust. I don't just want to know their business. I really want to teach them to mentally deal with any problems they might have." *Male, 18*

Concerns about stigma came up repeatedly in the survey. Respondents suggested that mental health care providers help young people grapple with the stigma associated with being in the foster care and juvenile justice systems, and also that they work to avoid making young people feel stigmatized for needing or receiving mental health care itself:

> "I would make sure that all youth know that they are not "different." People all have problems. People do not need to feel lessened by their role of foster youth. Being a 'foster youth' should not add to the stresses of foster care." *Female, 17*

> "Talk to me like I am normal. It feels like they want to get into my brain. Most kids are normal when you talk to us." *Male, 15*

"Do not try to fix me, just listen to me like a regular kid." *Male, 17*

Respondents stressed the importance of offering young people the opportunity to express their feelings in a context of trust, confidentiality and reciprocity:

"I would first share with him my past, tell him about my experience and see if we connect. Then I would ask him questions not related to his issue yet. I would build a relationship with the person first before I got into details of his problem." *Male, 20*

"I would offer them the opportunity to say what they have to say, just to express their feelings to someone so they can feel free, since they have it bottled up inside them. I would suggest that they tell the truth and be open no matter what. It don't matter if they want to cry – it's good to let things out. Everything is confidential!! But if you do not want to tell me anything it's okay." *Female 16*

SUGGESTIONS FOR MENTAL HEALTH SYSTEM IMPROVEMENT

- Have young people help set the agenda
- Address survival needs as well as psychological needs
- Meet in informal settings
- Emphasize strengths
- Support with compassion and consistency
- Reduce stigma

The programs profiled in the following pages hew to many of the ideals young people lay out for their own care, and could serve as models for productive statewide responses to the mental health needs of young people in the foster care and juvenile justice systems. While differing in approach and point of intervention, these programs share common elements: strong mentoring of youth; commitment of confidentiality; staying power; and building on what young people say they need most.

Case Study – The First Place

EMANCIPATING FROM THE INSIDE OUT

It is Friday night, and the storefront office of Oakland's First Place Fund for Youth is packed with two dozen teenagers and young adults eating pizza, talking with each other, and providing enthusiastic backup for the few brave souls willing to take the mike at the rented karaoke machine. A ten-month-old baby is passed from hand to hand, admired, and periodically offered the mike.

Would this be called a mental health intervention? The participants are all current and former foster youth – a group who, when asked, are likely to define their greatest mental health problem as loneliness and their greatest need as support and a chance to be heard. A Child Welfare League of America review of the range of programs serving older youth in foster care questioned the "high degree of focus on clinical and rehabilitation services" and lack of emphasis on "normative activities" such as school, work, friendship and recreation.[24] The First Place has skirted this distinction by placing its clinical efforts at the center of a genuine community of current and former foster youth.

A young man in black cargo pants and an oversized white sweatshirt with the hood obscuring his eyes stands up to read a poem from a piece of lined paper that shakes in his hand: "I'm not a bad man, I just act that way/I'm ready to learn/Other people are mysteries/I lived my life in misery for too long/I'm ready to learn." The room grows quiet. Then comes applause.

"Man, I can't sing with all you people looking," says the young woman who is up next, averting her eyes from the crowd. All the same, she does, to great acclaim. Meanwhile, former foster youth who are now First Place staffers quietly work the crowd, letting their soon-to-be-emancipated visitors know about the services and supports The First Place offers them.

Each year, a quarter million young people emancipate from foster care[25] and begin their adult lives on their own. Experts predict that this number will double in the coming years, as the wave of young people who entered foster care during the crack epidemic of the 1980s comes of age.[26] With little or no family or community to fall back on, and little support from the institutions that raised them, few are prepared for the independence that is thrust upon them virtually overnight when they come of legal age. Nearly half of all 18-year-olds leaving the foster care system do so without a high school diploma. Fewer than one in five is able to be completely self-supporting. In California, the Department of Social Services has estimated that 65 percent of the youth in its care face homelessness directly upon emancipation.[27]

Amy Lemley was a graduate student at the Goldman School of Public Policy at the University of California at Berkeley when she started researching the needs of emancipating foster youth in 1998. In San Francisco, Lemley found, the problem was particularly severe. The number of foster youth emancipating in that county had

increased by 600 percent over the previous seven years. Within the first few years out, one in three was receiving welfare.

Lemley got her degree in the spring of 1998. Then she did something unusual: she took on the problem she had described in her master's thesis. Together with classmate Deanne Pearn, she started The First Place Fund for Youth, which aims to give emancipating foster youth not only a roof over their heads but also the tools they'll need to keep it.

The First Place is part of a growing national movement to address the needs of emancipating foster youth. But The First Place is also different, both in its initial focus on "economic empowerment" and its evolving focus on mental health.

Foster youth, Lemley observes, may be given instruction in "independent living skills" – how to balance a checkbook or unclog a sink – but they have little or no access to a key ingredient of an independent life: money. The average 18-year-old leaves the system with $250 in her pocket – enough to live independently for just about a week.

Using a peer lending model first developed by the Grameen Bank in Bangladesh to support poor women starting small businesses, The First Place loans participants money for a deposit on an apartment – up to $1400, to be paid back (interest-free) over two years in weekly installments. Participants are divided into "loan classes" of eight to ten people, who cosign each other's loans and decide when each member is ready to receive one. This means that peer pressure is available to make sure loans get paid back promptly, but also, more subtly, that participants develop relationships, a community that takes collective responsibility for its members – something many foster youth have never had.

After participants move into their apartments, they pay ten to thirty percent of their monthly income in rent; The First Place picks up the rest. Along the way, they take classes in "economic literacy" and are encouraged to open savings accounts, apply for scholarships and seek higher-wage employment. After two years, they can keep their apartments but must pay market rent. Thirty percent of First Place housing stock is in permanently rent-protected non-profit developments. Once participants pay their loan back they can apply for another to pay for college or buy a car.

It didn't take Lemley and Pearn long to realize that their carefully-laid plans were missing a crucial element. "The First Place evolved in a way that is not uncommon for community-based organizations," Lemley recalls – "with a strong emphasis on services and a really serious under-appreciation of the complex mental health needs of our youth."

With her bobbed brown hair, black-framed glasses and intensely thoughtful manner, Lemley still has the appearance and demeanor of the graduate student she was when she conceived The First Place six years ago. "The bottom line is, the way we started didn't work," she says bluntly. "Youth weren't keeping their jobs. They weren't paying their rent. They were just blowing smoke our way as far as their drug use."

"We didn't have the muscle built to be strong enough for the young people we were serving," Lemley says she and Pearn ultimately realized, "until we developed a mental health perspective."

FRAPPACINO THERAPY – SUPPORT WITHOUT STIGMA

In 2000, The First Place hired Widd Medford, a Marriage and Family Therapist (MFT) with an extensive background working with vulnerable youth. They gave him the title "emancipation specialist," an intentionally neutral designation intended to skirt young people's anxieties around being labeled, stigmatized or perceived as "sick" by mental health professionals. And they assigned him to work with those young people most likely to struggle upon emancipation: foster youth who were in group homes, had been in multiple placements, or had histories of gang or drug involvement. About a third of Medford's clients have been involved with the juvenile justice system as well as the foster care system.

Medford and two MFT interns whom he supervises work with young people who are nearing emancipation. Each young person sees an emancipation specialist once a week for an outing and conversation. In fiscal year 2002-2003, 70 young people received intensive clinical case management through the First Place's Emancipation Training Center.

Medford brings his mental health training and perspective to these relationships, but he does so in a low-key way that does not raise red flags for young people who may be suspicious of those they perceive as trying to treat, change or fix them.

"A lot of youth have had negative experiences with therapy," Lemley observes. "The group home pulled the kid down the hall and said, 'I don't care what you're doing, you're going in that room. This is required.'"

At the same time, she notes, young people on the brink of emancipation "need a person to talk to. They need someone to help them address all of the unresolved angst, rage, conflict, and trauma that they have experienced. Widd is essentially a vessel for that on an ultimately consistent basis."

Medford, who also sees young people who are not in foster care in his more traditional private practice, says he skirts his First Place clients' resistance to "therapy" by talking with them in a Starbucks or Baskin Robbins – practicing what he calls "frappacino therapy." The conversations he holds over coffee or ice cream, he says, are similar to those he holds with private clients in his office. The main difference is that they do not carry the name "therapy," with all that it connotes to those who are overly accustomed to being treated as flawed, damaged, or simply in need of help.

Initial meetings often focus on young people's practical needs – for housing, a job, a stable placement, and help with school. Whatever the topic, Medford says, "the first thing I look for is the mental health issue. I assume every kid is going to have one. It's not about giving them some sort of label, or assuming they are faulty in some way, but every kid that has been through this system has had some form of trauma that has impacted them. And you can't just ignore a trauma."

A few of his clients, says Medford, have more severe mental illnesses such as bipolar disorder or schizophrenia. When necessary, he refers those clients to doctors who can prescribe medication, and helps them apply for SSI when appropriate. More commonly, he sees young people who suffer from depression or post-traumatic stress disorder – often undiagnosed and untreated – as a result of, or exacerbated by, their experiences in their families of origin and in foster care. Medford aims to address his clients' multiple needs through a combination of talk therapy and concrete practical assistance.

The goals of the program are to increase the odds of a successful emancipation by stabilizing a young person's placement, supporting his educational progress, and addressing his mental health needs. Each aspect of the program bolsters and facilitates the other. Without having their basic survival needs addressed, emancipating foster youth are unlikely to be able to focus on personal or mental health issues. But without having those psychological issues addressed, they are likely to have a hard time finding the focus they need to stabilize their lives.

With his rugged face and the traces of a drawl, Medford evokes the young Bill Clinton. His manner towards young people is matter-of-fact: he doesn't use professional jargon, nor does he pander by trying to sound 16. Lemley describes him as "the ultimate blank slate:" his warm yet neutral manner makes wounded kids feel safe.

The technical term for what Medford does is "therapeutic case management." His "cases" are more likely to refer to their therapist as their friend, and – perhaps more importantly – perceive themselves as his friend.

The concrete results of this therapeutic friendship are encouraging. Of the 15 youth served in fiscal year 2001-2002, 11 received a high school diploma, GED or another equivalent degree – more than twice the average for emancipating foster youth.

When he begins work with a new client, says Medford, "I don't expect them to trust me. They'll tell me, 'I've had 52 different social service providers in my life and I don't trust any of them.' So I just try to be consistent, let them know that I'll do what I say, and that I will not violate their confidentiality unless it's a life or death situation."

This last is important, Medford explains, because many of his clients tell him that previous therapists have, in their view, betrayed their trust. If a child is a ward of the court, the presiding judge in family court holds the privilege a parent normally would to be apprised of a minor's progress in therapy. This privilege is often assumed by agents of the court, including social workers, with whom therapists may share information. That information gets incorporated into the reports social workers submit to the court. When young people know this – as they often do – their ability to trust a therapist is seriously compromised.

Medford says he addresses this issue with social workers the same way he does with parents in his private practice: he tells them that he is aware they have the right to know what goes on when he meets with young people, and of his own responsibility to disclose any indications that a young person might be a danger to himself or others, but points out

that if they require disclosure beyond that, he will lose his clients' trust and negate the therapeutic relationship.

Medford's discretion and consistency – the fact that he keeps his promises – are themselves therapeutic, Lemley believes.

"We're not just dealing with mental health issues that result from what happened with people's parents," she notes; "it's all of the mental health issues that stem from the betrayals they've experienced in foster care. They've had so few people who follow through with anything. So just by being someone who consistently under-promises and over-delivers, Widd is teaching them that not all adults are bad; that it can be safe to trust someone and safe to build a caring relationship."

PROFILE OF SUCCESS: TASHA

Tasha has been diagnosed as having major depressive disorder, and has made several suicide attempts. Her first out-of-home placement was, to use her term, "the crazy home." She was twelve years old when she found herself on an adolescent psychiatric ward.

"It felt weird," says Tasha, who perceived her commitment as a punishment she did not deserve, "but then I just played the role. They thought I was crazy so I played like I was crazy. When they came in my room I'd just run back and forth."

After Tasha was released from the hospital, she embarked on a series of group home placements. Today, she speaks of "not caring," even about herself.

Medford meets with Tasha weekly and is regularly available to her. That fact alone has helped her begin, albeit tentatively, to see herself as valuable.

"Something I'm doing must be right for somebody to take their time out to help me," she says. "You know?"

What is she doing right? "It's kind of hard to say, because I don't really know myself. Probably the personality... I think Widd likes my conversations, my interesting conversations."

When she was initially placed in the foster care system, Tasha was assigned a therapist. "I forgot her name," she says. "I never did know her name, actually. I didn't really like therapy because they talk to you as if, 'Oh, I know what you're doing. I understand.' You can't understand a child because you're not that child. We all have different feelings. We're all equal, but we have different feelings."

Tasha resented the questions the therapist asked about her family and her childhood, believing they were "none of her business." The relationship ended when Tasha cursed the therapist out and never returned. A therapist's job, she now concludes, is to "make people think that they are crazy so they can get paid."

Tasha now insists she "doesn't need no therapist." But everyone, she concedes, needs someone to talk to. Tasha speaks with Medford about the issues her therapist tried to get her to address – her family history and childhood traumas – but believes she does so voluntarily rather than as a result of prodding: "If it pops in, it pops in."

"If I were to be a therapist," Tasha volunteers, "I wouldn't just let the child talk. I'd talk, too. As much as the child opens up to you, you open up to the child."

Her relationship with Medford, as Tasha describes it, is based on this kind of reciprocity. She sees him not as a service provider but a "big brother, or uncle – Widd is like family."

"Until she starts driving," jokes Medford, who is present for part of the interview. "Then I'm out of there! Tasha is a road rager."

Medford and Tasha begin to kid around about her habit of flipping people off when they cut her off in traffic, or demanding they pull over and fight. The banter about road rage, Medford explains later, is a way for him to assess Tasha's state of mind, and the level of her anger.

At Starbucks, Medford knows what Tasha likes – a caramel frappacino with extra syrup – and orders it for her. He knows her birthday; her favorite color; which TV shows she likes. The familiarity and predictability this builds, says Medford, provide what therapists call the "frame" for their relationship – a contained and familiar space that in traditional psychotherapy comes from a regular meeting in a clinician's office.

"Tasha has all this potential that is just waiting to be mined," Medford says, "but I don't think she truly believes it yet. By just bugging her on a weekly basis—joking, kidding with her, playing cards at Starbucks – I want her to begin to see, 'Hey, you can have a different life. You are a great kid.' And hopefully when she finally sees it, she takes off."

On the practical front, Medford's major goal for Tasha is to help her graduate from high school or obtain an equivalent degree. Although she is clearly bright, she missed months of school at a time as she moved from one placement to the next and is short about 80 credits towards graduation. She recently tested at a third-grade level in reading—a score, she says, which indicates that she is "probably retarded."

Medford offers her another way of looking at herself and her prospects. "Tasha has personality plus, as you can tell," he says in her presence. "She'll have no trouble getting a job. We just got to get that little piece of paper to help her get in the door."

"That's another thing about Widd," says Tasha. "He got confidence in me like I don't even have in myself."

PROFILE OF SUCCESS: JEROME

Jerome is 17 and lives in a foster home from which he will emancipate sooner than he would like. He has been involved with The First Place since he entered foster care at 15.

A placement worker referred him to the program after he went through five group homes in as many months.

Jerome is unusual in that he has actively pursued counseling, starting in junior high school. His father had left the family and his mother was growing increasingly abusive. "I knew I needed somebody to talk to," he says, "because I held everything inside of myself."

Despite his desire to communicate and be heard, Jerome's fear of his mother – combined with an impulse to protect her – made him guarded in his conversations with the school counselor whose help he sought. He told the counselor that he was unhappy, but withheld most of the details.

In high school, Jerome again sought help from a counselor, who referred him to a community mental health agency. During the intake interview, Jerome disclosed the abuse that was taking place in his home. The intake worker told Jerome that she was required to make a report to Child Protective Services (CPS), which sent a worker to visit Jerome's home, but did not remove him.

After that, says Jerome, things went from bad to worse. His mother stopped speaking to him or buying him food. The physical abuse escalated. CPS continued to monitor the family but, Jerome says, believed his mother's false account of what was happening and did not deem further intervention necessary.

Meanwhile, Jerome was assigned to an individual therapist through the community agency. "I liked going to counseling, because I was able to talk to somebody, but I wished I could tell them more," he says. "When my mom would hit me, I wouldn't tell them, because I knew they were going to report it, and I was scared of what my mom would do."

When Jerome was 15, his mother beat him so badly that he called the police. At that point, Jerome entered foster care.

Jerome has continued to see the same therapist for several years, and feels he has benefited from the care he has received. But he has never been able to trust completely in the therapeutic relationship, because he has never experienced confidentiality.

This lesson was driven home when Jerome told his therapist that he was bisexual. Not long after, his social worker visited him at his school and began asking him questions about his sexuality. Jerome continued in therapy, but his sense of betrayal made him close down even further. His sexuality was now off limits, just as the abuse he had experienced at home had been.

Jerome felt further constrained by the formality of the therapeutic setting. He says he felt like he was "in a doctor's office every time. You sit down and you do the whole formality thing. I didn't feel like he was my friend. I didn't feel safe, in the sense that I could be totally open with my feelings." The fact that the therapist took notes was another

distraction, once Jerome discovered that those notes could be made available to the child welfare department.

This is the experience Jerome brought with him to The First Place, where he worked first with Widd Medford and later with Brian Oltman**,** an MFT intern. Jerome understood that Medford and Oltman were also mandated reporters; that they would have to disclose any indication of abuse or endangerment. But they did not take notes, and they didn't limit their interactions with Jerome to the confines of an office.

Each time Jerome moved to a new placement, The First Place tracked him down. "Every time I'd move it felt like I would lose everything" he recalls, "but they never left me. They were always there, so I could always have someone to talk to."

Jerome developed a particularly close bond with Oltman, whom he says saw him through a period of intense personal change. "He was somebody I could talk to and who would talk back to me," Jerome says. "Someone who I could freely voice my opinions and my feelings to, and I wouldn't be judged because of that. That's what I had been looking for."

Jerome's faith in Medford and Oltman was bolstered by the fact that they got results on a practical level. When Jerome was having trouble in a placement, they spoke with his social worker. When his clothing allowance was held up, they got on the phone again. When a treasured French dictionary disappeared during a move, Medford bought Jerome a new one. The bottom line has been that when Jerome tells Medford or Oltman about a problem in his life, the situation gets better, not worse. That simple fact has laid the groundwork for trust, and so for a therapeutic relationship.

After he emancipates, Jerome plans to attend junior college and then a four-year university. Medford and Oltman have walked him through each step of planning for his future: lining up housing and employment; applying to college; seeking financial aid. His relationship with The First Place, Jerome says, has helped him go from being so afraid of independence that he "couldn't even see myself in the future" to feeling able to plan for and even look forward to turning 18.

"Sometimes when you have a lot of things going on your life, everything is like this big cloud around your head," Jerome says. "Brian and Widd helped me take things out of that cloud and deal with them one at a time. That's what I needed. And that's how I ended up growing as a person."

LESSONS LEARNED FROM THE FIRST PLACE

- Offer a realistic expectation of privacy.
- Be consistent.
- Offer a neutral setting when stigma is an issue.
- Create a sense of reciprocity.
- Forge "bridge" relationships that begin in foster care and continue after emancipation.
- Address survival issues along with psychological needs.

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Youth Voice: Chris

"The same way you'd raise your kid is the way to deal with us."

Chris, 21, entered foster care at eight, after his mother's death, and spent his teenage years in group homes and juvenile hall. He is now living independently, working full time and attending college.

The first time I saw a therapist, I was about 11. It was cool. We talked a lot, played board games and stuff.

I probably saw five different therapists while I was in the system, maybe even more. There were some that were really nice to me. They took me out to eat or whatever and then just talked to me.

But eventually, living in the system, you get frustrated. I was bouncing from place to place—emergency foster homes—for about three months each location. I would get mad and yell and scream, break a lot of stuff. That's probably why they started prescribing me pills.

After that, I was seeing a psychiatrist, and every visit was to determine if I needed the medication or not. Every time I said "No, I don't need it," they still would insist that I did. But pills aren't going to put a glitch in your brain that says, "OK, don't get mad, just be happy." The only thing they did was take my energy away. I felt like I was drugged.

They told me I had a chemical imbalance, which, I don't know, I probably did. But I felt that I just had the same issues as any other kid, and the reason that I'm getting the prescription is because I'm a foster kid. The people I lived with had kids too, and they were worse than me, but they weren't getting medication, because they're the "real kids."

I needed somebody to talk to me, to understand where I'm coming from. I'm a kid, you know? Going through some stuff. People should work with me instead of trying to give me medication to suppress whatever I had to say or feel.

I would go to see the psychiatrist once a month, and my foster mother would come along. First she would talk to him one-on-one, then we all talked together. I didn't like that, but at that point I didn't really care anymore.

The key thing that helped me deal with my anger was the last group home I lived in. I was transferred there from juvenile hall. I was only there for eight months, but Dave Hernandez, who ran it, really worked with me. He just came up to my face and dealt with me one-on-one. Dave basically saved my life.

I'd been in juvenile hall before I went to Dave's, and was at a crossroads. I was possibly facing three years in the California Youth Authority for some trouble I'd gotten into.

When I first got to Dave's group home, I went on a rampage. I went to the malls and stole stuff, and Dave found out about it. I got into fights and did horrible in school. But Dave still gave me a chance.

I had always wanted to go to college, and Dave got me back on course with that. He made me confront my issues. He has a way of working with kids where he knows what you're going through. He knows what you need, which is, you need care. You need somebody to talk to, somebody to confront your issues with, because your whole life, people were afraid to help you. They look at you and look at your case file and they say, "Yo, this guy is bad news."

Dave knew how to work with kids. The same way you'd raise your kid is the way to deal with us. Because when you look all the issues of the different kids, they're all based on the same thing, which is what any kid needs. Love. Somebody that cares. Someone to talk to.

We all have our own issues, but we hide them, cover them up, tell ourselves lies. What Dave does is help you realize what your problem is. How come you're so mad? It might be something that happened when you were five, but he helps you dig into your roots.

One thing that helped was being around him all the time, because that seems normal. When things come up, you work on it. You don't just say, "OK, we're going to sit here once a week and we're going to talk about it." At Dave's, it was more like a normal family. Like if it was your kids, you're not going to say, "OK, this day out of the month we're going to talk about your problems."

The reason I was always mad is because of the stuff that happened to me – my mom passing away, and then going into foster homes. After a while, you put yourself in this little room. Anything that happens, that's your excuse. You don't see out of that. Then somebody shows you something that brings you out of it, and you start to focus on the good things that you have going for you. Then you start achieving things that boost your self-esteem.

Dave found the things I was good at, like art, and made them part of my life. Eventually I realized, "I don't need to be mad and angry like I was before. I got all this stuff going for me in the present. I can draw, I can paint, instead of dwelling on all the old issues, which causes me to be angry."

When people are leaving foster care, they need a lot of support. This transition we're making into the real world is a lot more than a person making that transition from their home. They are still kind of connected, but we are not connected at all. We're officially out there on our own and we're trying to survive. I feel like what I need is a lot of people I can talk to and rely on if I need help.

I do think it's important to have psychologists or therapists available as a resource, because there are some kids out there that need that. But there are also other people who don't need that, or need medication. They actually just need somebody to talk to. So

don't be so quick to prescribe a pill to someone if they have an anger issue. Try to work with them, you know?

I know that's an easy thing for me to say, and the kids probably need a lot of work. They didn't grow up a normal way, or with a lot of people to support them, so they're going to need ten times more support now. It's a tough task. But that's the only way to do it.

Expert Insight: Dr. Michael Malkin

"What is needed with difficult cases is very close case management."

Dr. Michael Malkin, director of juvenile mental health services for Los Angeles County, oversees the Los Angeles County Juvenile Mental Health Court, which was launched in 2001.

There is a national problem with juvenile offenders having a variety of mental disorders, and a concern that their mental health needs are not adequately met. A survey that was done in Los Angeles found that between 20 and 40 percent of kids admitted to juvenile halls had significant mental health problems that needed immediate treatment.

The juvenile mental health court was developed to deal with kids in the delinquency system who had mental health problems. The idea of the court is that it would be a venue for spending more time and attention on individuals who have a lot of high-intensity needs. What was created is a delinquency court in which the judicial officer, prosecutor, public defender, probation staff, a school counselor and the health department all form a team to handle these cases. We also have two psychologists who are the primary mental health staff on the team.

JUVENILE MENTAL HEALTH COURT

A specialized team focuses on delinquent youth who have mental health needs. Team members include:

- Judicial Officer
- Prosecutor
- Public defender
- Probation staff
- School Counselor
- Health staff
- Mental Health staff

Everyone on the team has an interest in mental health and some expertise in dealing with it, and has made a commitment to work together, so it's a much less adversarial system than would typically be the case in a delinquency court. In addition, they have a lot more time to devote to making sure these kids get the services they need. What comes out of this is a sort of super case management process. The team as a whole is able to make sure that the kid is getting the services he needs; that he is cooperating with the services; and that the public agencies that are providing the services are doing what they're supposed to do.

There is a whole spectrum of mental health services a young person might receive, ranging from kids who are at home with their parents getting outpatient treatment in the community to kids who are hospitalized at the highest level of restrictive, intensive treatment. The mental health court hasn't created any new resources in terms of treatment. Probably the best thing we do is expeditiously and judiciously make use of the resources that are out there.

Kids present with a wide spectrum of problems, from those who are classically bipolar or schizophrenic to a lot who probably have impulse control disorders from prenatal alcohol exposure. The court follows good mental health principles that work with all kinds of

populations – what is needed with difficult cases is very close case management. There's someone checking in, making sure they're taking their medication, and showing up for whatever they are supposed to show up for. For people who have chronic problems, this has been demonstrated a million times to be the sort of thing it takes to get success.

Case Study – The Mentoring Center

TRANSITION AS TRANSFORMATION

In an airy ground floor office in Oakland's Preservation Park – a downtown oasis of restored Victorians arranged around an emerald courtyard – a group of young men pass around McDonald's french fries and apple pies while they assess whether they can plan and execute a large barbecue with less than a week's notice.

Mentoring Center Executive Director (then Program Coordinator) David Muhammad stands before a sheet of butcher paper, red marker in hand, a cell phone and pager hanging from the waist of his blue corduroys. As quickly as he lists tasks and duties – recreation, transportation, food, space, invitations – names of volunteers go up beside each task.

A broad-shouldered 23-year-old in a shiny silver football jersey and gleaming silver Nikes signs up to round up bats and balls, and says he'll be in before nine the next morning to start making calls. A round-faced 17-year-old volunteers to bring some dominoes from home; he also pledges to show up early the following morning to get started on invitations.

The atmosphere is jovial but efficient. The young people here are clearly enjoying both each other's company and the prospect of pulling off something challenging together.

The young men assembled in the Mentoring Center's sunny office, its walls adorned with upbeat slogans and inspirational posters, first connected with the program in a very different setting. They are all graduates of the Center's African American Males Transitions program, which operates inside the CYA facility in Stockton.

The 24-week Transitions Program, says Muhammad, "is about trying to change the way young people see themselves – what some people call cognitive restructuring." To that end, Mentoring Center staff take CYA wards through a series of scenarios designed to improve their decision-making – a crucial skill for soon-to-be-parolees, who often risk reincarceration for the slightest slip-up.

"You're two weeks prior to getting out and someone calls your mother a b——," Muhammad will ask the group. "What do you do?'"

"Of course the knee jerk response is, 'I hit 'em'," Muhammad recounts. "But the benefits of that are what? You feel good about hitting someone who cursed your mother. The costs are time added to your sentence. You're put in lock-up. And your mother would rather you not hit the person, so you could get out! When they see it laid out like that, they come up with a different answer."

Upon their release, Transitions participants who are paroled to the Bay Area can – and almost always do – join the Center's weekly Positive Minds group. In July 2003, The Mentoring Center launched two additional programs. Pathways to Change offers case

management to low-level offenders who are diverted from juvenile hall, and Project Choice provides pre-release support and two-and-a-half years of post-release case management to 20 parolees from CYA Stockton.

The question of what heals – at the center of any discussion of mental health – is also, in the case of juvenile justice, the question of what rehabilitates. Each Mentoring Center initiative operates from the same premise: that internal change is as important as practical support in helping young people turn their lives around.

"If a young person gets out and you get him a job but you don't change his mentality, he's just going to go from robbing you on the street to stealing from the register," Muhammad observes. "Our mantra is changing the mentality that gives rise destructive behavior."

There is evidence that strong mentoring relationships can have a direct impact on mental health. A research brief from Child Trends concluded that teens who have positive relationships with adults outside their family are more social and less depressed than those who do not.[28] Similarly, a study of pregnant and parenting African American teenage girls found that those who had relationships with an older person who was "trusted, loving and experienced in the guidance of others" had lower levels of depression than those who did not.[29]

The context for The Mentoring Center's work is a city that has been called the ex-con capital of California; a city where one of every 14 adult males is on parole or probation.[30] Those who enter the criminal justice system as adolescents often leave it on the brink of adulthood, creating a deeply fraught transition. Troubled to begin with, they leave youth facilities with minimal job prospects; months or years of immersion in a criminal culture under their belts; and the trauma of juvenile incarceration weighing down their psyches.

"I think every one of our young men has a post-traumatic stress disorder," asserts Muhammad – "from incarceration as well as whatever problems caused him to do whatever got him locked up. That manifests itself as depression; a lack of focus; emotional outbursts. The other part is there is a lot of drug use, and our experience has shown that much of that is a kind of self-medication."

A 2002 report from the Center on Juvenile and Criminal Justice – based on interviews with parole agents, service providers, researchers and former wards – found a number of barriers to successful reentry for juvenile parolees, including lack of educational options; lack of housing; limited skills and education; lack of community supports and role models; substance abuse problems; institutional identity; and mental health problems. The Mentoring Center addresses each of these needs individually, but also operates from an understanding of their interrelation.

According to Muhammad, the recidivism rate for parolees who continue to work with The Mentoring Center after their release is about 15 percent – a huge improvement over the CYA average of 91 percent.[31] But The Mentoring Center – which operates under the motto "Where young minds cannot fail" – takes that 15 percent very seriously.

When Mentoring Center staff began to look closely at the handful of young men who were having a particularly difficult time staying out of trouble, a pattern emerged: they all had mental health issues, substance abuse problems, or – often – both.

Muhammad recalls one young man in whom The Mentoring Center invested significant resources. They found him a place to live and, when they learned he was using crack cocaine, enrolled him in a 30-day inpatient program, twice. When the young man completed his second stint in rehab, The Mentoring Center helped him land a 16-dollar-an-hour job and bought him a car so he could get to work.

For a month, the young man held on to both. Then he got his first check, relapsed on crack, and sold the wheels off his car. When Muhammad challenged him about his drug use, the young man revealed for the first time that he suffered from delusions – voices he had tried to quell with illegal drugs. It turned out he had been diagnosed with bipolar disorder and schizophrenia and had been medicated for these conditions while incarcerated, but the medication was abruptly discontinued when he was released.

Another Mentoring Center client brought home the danger of failing to address mental health problems in an even more devastating manner. This young man had come through the program both in and out of CYA, and was doing so well he received several awards from community organizations. Then he relapsed into heavy drug use and lost contact with The Mentoring Center. Later, Muhammad and his colleagues learned that the young man had turned to prostitution to get money for drugs. Only after he murdered a man who was paying him for sex did it become known that he had been sexually abused as a child – a legacy of trauma that went unaddressed with tragic consequences.

Since these incidents, and the self-examination they prompted, mental health has become an increasingly important element of The Mentoring Center's work. The Center recently hired a licensed clinical social worker to assess each participant and make sure that mental health concerns do not go overlooked. Staff also make referrals as needed to individual therapists.

Muhammad is well aware that many of his clients have negative attitudes towards – or have had negative experiences with – mental health services, but relies on the trust he and his colleagues have developed, sometimes over years, to smooth introductions and overcome preconceptions. The Mentoring Center also works to recruit therapists who share their clients' cultural background and understand their experiences.

While making referrals for those young people who have significant mental health problems is increasingly a part of The Mentoring Center's efforts, there is also a therapeutic component to the individual mentoring the Center provides. In fact, what founder Martin Jacks has dubbed "transformational mentoring" – in which mentees receive not only companionship and practical support but also help in changing negative thought patterns – might also be called therapeutic mentoring.

The Mentoring Center's work is grounded in what Jacks has called "the traditional or natural version of mentoring," in which adults from a particular society mentored the

young in an effort not just to develop their character but to pass on social and cultural norms. Mentoring as it has evolved in recent decades, Jacks has argued, has moved away from this latter mission and focused instead on “fixing” problem youth rather than preparing all youth to assume their place in society.[32]

Lawrence Colación, an Oakland parole officer who works with young men coming out of CYA, says the fact that many of his clients have already formed relationships with Mentoring Center staff while incarcerated makes the Center a particularly valuable resource once they get out. Many of his clients, he says, are already prone to depression; when they leave CYA as young adults whose formative years were spent behind bars, their threshold for frustration and rejection is low. If they don’t find work – or some kind of positive reinforcement – right away, their depression deepens and they may simply give up.

“I refer guys to EDD (the Employment Development Department) all day long,” Colación says. “They go through orientation, and unless someone takes them aside right away, that’s it. With The Mentoring Center, they have a relationship already. They feel, ‘Hey, this person cares about me.’ There’s that one-to-one connection. I can say, ‘You’re getting out? Go see David.’ It’s seamless.’”

PROFILE OF SUCCESS: CURTIS

Seventeen-year-old Curtis puts down the book he has been reading and begins to speak. For the next two hours, he pauses only to catch his breath.

In pressed black slacks and a black and white checked shirt, towing a briefcase stuffed with books and papers, Curtis seems at once anxious and exuberant – wringing his hands nervously until his narrative kicks into high gear, then releasing them to gesticulate dramatically or pound the table for emphasis.

On this summer afternoon, Curtis has good reason for both exuberance and anxiety. At ten years old, he became the youngest child ever sentenced to the CYA, which houses the state’s most serious juvenile offenders and can keep wards up to the age of 25. At 16, he was released and paroled to Southern California, where he had lived as a child. Months later, he moved to Northern California to live with relatives and be closer to The Mentoring Center, the Oakland-based program he credits with transforming his mind and his life.

Curtis grew up in Southern California among “gangs, violence, drug addicts, drug dealers – my whole life was surrounded by chaos.” When he was a young child his father began using and selling drugs, and became physically abusive towards Curtis’ mother. More than once, he threatened to kill Curtis and his brother.

When Curtis was five years old, his parents divorced and he and his brother remained with their mother. Not long after, his father snatched the boys as they played outside the house and took them away with him. For eight months, he kept them in what Curtis describes as a crack house, where addicts came and went throughout the day and night.

Sometimes, their father left the boys alone in the house without food for days. Finally, Curtis' mother obtained a court order and the boys were returned to her.

"All that made me very angry, very bitter inside," Curtis recalls, "but at the time, I didn't know how to deal with those emotions. All around me, people would express their emotions through violence, so that was the only way I knew."

At school, when Curtis felt belittled by a teacher, he would lash out – making threats, throwing chairs. A school psychologist diagnosed him with Attention Deficit Hyperactivity Disorder and referred him to a therapist at the county mental health department. He was later diagnosed with bipolar disorder, and prescribed medication.

At the time, Curtis says, these diagnoses only amplified his despair. At home, a new boyfriend was abusing his mother just as his father had. He was still surrounded by gangs, drugs and violence. When he lashed out in anger he was told the problem was him, and given medications that he had trouble distinguishing from the drugs that had destroyed his father and divided his family.

"I was getting counseling," says Curtis, "but at the time, I felt like, 'Man, how's somebody who's never been through what I went through, who doesn't have to live in the conditions that I live in, telling me that it's going to be OK?"

"Just talking about the problem don't change the problem," Curtis observes. "You have to take steps to change the situation and the circumstance. You must have some other alternatives. And they didn't give me no other alternatives. They didn't give me solutions, or steps to changing my patterns. All they told me was, 'Take these meds and it's going to make you feel better.' It was all about my responses and not so much about my environment. But the root of what I became at that time was my environment." After a year in therapy, Curtis simply stopped going.

At seven, Curtis was arrested for stabbing a teacher with a pencil and spent the afternoon in juvenile hall. By eight, a neighborhood gang was sending him on "missions" to steal food from stores. By nine, he was carrying a gun. By ten, he had been in ten juvenile halls and 20 group homes across the state.

"Eventually," Curtis says, "I became totally desensitized. Cold hearted. I really didn't care what nobody was feeling. I just wanted what I wanted. And I progressed in violence."

At ten and a half, Curtis found himself in the CYA after he participated in a fight in which a juvenile hall counselor was injured. Sentenced to two years, Curtis got in so many fights, had so many violent outbursts, that he wound up serving six and a half.

His fury over what he had been through, and at his present state, was so overwhelming, he says now that "I just hid it. In the recesses of my memory it was still there, but I didn't want to deal with it. I tried to hide it, to cover it, but I was angry. And because I was angry, I acted out violently."

"Whether it was shanking someone with a knife or beating them over the head with a chair," Curtis says, "I was making a point. The point was 'Don't mess with me.' But at the same time, it was a way of releasing my anger, of channeling that energy."

Curtis' rage earned him monthly visits with the staff psychologist, and more medication. The drugs, he says, "suppressed my feelings, but didn't change my problems." At 12, he says, he began hiding the pills under his tongue and bartering them to other wards for noodles from the commissary.

"Everything I was feeling inside didn't change, whether I was taking the meds or when I came off the meds," he says. "When I started dealing with my issues – getting new information, re-educating myself – that's when I started changing."

"Fragmented" is the word Curtis uses to describe his mental state during his early years at CYA. "I felt like I was cut into pieces," he says. There was the part of him that had been hurt as a child, a part that remained locked in the past. There was his present self, incarcerated with men as much as a decade older than he – a self cut off from the child he still sensed himself to be. His future self he could not even imagine.

This sense of fragmentation worsened when, at 12, Curtis was consigned to an isolation cell after a series of fights. He spent 23 hours a day in his cell, his primary human contact the nurse who brought his medication twice a day. If he banged on the walls or threatened suicide, he recalls, a psychiatrist sometimes materialized.

It was a year before Curtis emerged from isolation and re-entered the general population. Now a teenager, he was tired of repeating the same cycle of violence and punishment, but didn't yet know how to break free of it.

He began paying attention to a group of wards whom he had not noticed before. Older than Curtis, they also seemed more focused, more organized. They always seemed to be carrying books. Some were taking college correspondence courses. When they were faced with the kind of conflicts or affronts that Curtis was accustomed to settling with violence, they talked their way through them.

Curtis admired these young men, but he didn't know how to approach them, much less become them. Then someone told him about The Mentoring Center's Transitions program, and he went to his first meeting. Several of the young men he had been watching were there. So was Mentoring Center founder Martin Jacks.

After the class ended, Jacks approached Curtis – by far the youngest boy in the room – and embraced him. "He said, 'Brother, you have potential,'" Curtis recalls. "'You have the potential to be great and do great things.' I was like, 'I do? That's not what the staff on the hall is telling me. That's not what the captain and the superintendent is telling me. They're telling me I'm going to be locked up for the rest of my life!'"

"Just that hug right there – knowing that somebody cared – that sparked the good in me," Curtis recalls. "Somebody was reaching out, extending themselves to me. Showing love. I was like, 'Man, I'm going to come back here.'"

Curtis marks this moment as the beginning of his recovery from insanity, defined in the way that most resonates with him: the compulsion to repeat the same actions over and over, each time expecting a different result.

"I didn't want to keep getting locked up," he says. "I didn't want to keep getting slammed on the ground by the staff, getting maced, getting pepper sprayed, getting handcuffs put on me. I didn't want that life, but at the same time I kept doing things that got those results. So I was insane in that aspect."

How to turn that insight into action remained beyond Curtis for quite some time. He went through the Transitions program several times – reading more books, according to Muhammad, than anyone in the program's history –but continued to have violent outbursts, and to suffer the consequences.

"It don't matter how much knowledge you have in your mind, but if you don't deal with your emotions….." Curtis' voice trails off, then picks up again. "It's like that child in me still needed to be healed from the wounds of the past." He begins to list those wounds: sexual abuse; his father's violence and neglect; witnessing men attacking his mother; being separated from her and shipped from one institution to the next.

Curtis began speaking about these things to a sympathetic CYA counselor. He was also seeing a CYA psychologist twice a week, and began to open himself up to the benefits of formal therapy. He describes the therapist as "a really good man, who was trying to help me. He felt for me, I believe – to a certain extent."

That caveat stems from Curtis' understanding that the sessions were not confidential. Other staff would reflect the therapist's analysis back to Curtis – "He wants to put you on meds because he feels like you can't cope;" "He says you've got a chemical imbalance."

"In the system, I'd seen people break their trust against me over and over," Curtis says. The therapist "helped me, but I could only go so far with him."

"He could only take me to that place where I could see what my problems were," Curtis concludes. "He couldn't help me solve them. He could diagnose me, but he didn't have no cure to heal me."

Today, Curtis says, he feels "whole, balanced, interconnected," rather than fragmented and alone. What has allowed this healing to happen, Curtis believes, is his deepening relationship with God, and its reflection in relationships with other people. When he begins to list names, they are all Mentoring Center staff.

Muhammad, Curtis says, "is like a brother, a father, a friend. He's a father because he will get on my case if I do something wrong. He's a friend because he's always there for me, no matter what. And he's a brother because there's a love there – a family bond."

PROFILE OF SUCCESS: MICHAEL

Michael introduces himself with a list of affiliations: "My name is Sergeant Michael Waters, U.S. Army. Jackson State University. Education major. I'm 23 years old."

His pride in these connections is visible in his voice and posture as he lists them. It is also remarkable, given how profoundly disconnected he has felt for most of his life.

When Michael was in the seventh grade, he discovered that his mother was addicted to drugs. He says he rebelled in response, spending his time with young men in his neighborhood who were already involved in crime.

By the ninth grade Michael, who had always been a good student and a serious athlete, was "living a double life. I'd get all As in school, come home and be selling drugs on the block. When three o'clock rolled around, I took my school clothes off, got into my turf clothes, and got out there."

Michael used the money he made selling drugs to help care for his nine younger siblings as his mother slipped deeper into her addiction. There was often no food in the house, and eventually his mother began selling the children's toys.

After a friend got shot coming home from school, Michael began carrying a gun. After high school, he says, "I just figured there wasn't going to be nothing else, so I'd just finish out my little high school term and go into drug dealing full time."

His plans were thwarted by a neighbor who reported Michael's drug dealing to the police. They did not have enough evidence to arrest him, but Michael was unable to contain his anger at the neighbor. Today, Michael sees the neighbor as someone who was trying to help him, and believes his rage towards her was actually displaced anger at his mother. At the time, that kind of psychological insight was unavailable to him. He made six sticks of dynamite from instructions he got off the Internet and blew up the woman's house.

The house turned out to be empty and no one was hurt, but Michael gives himself no credit for that fact. "I was trying to kill her, her two kids and her mom," he says. "I had no remorse, didn't care about nothing but myself." He was tried as an adult and, at 14, sent to state prison.

After 18 months, his lawyer successfully appealed his transfer to the adult system and Michael went into the CYA, where he soon joined the Transitions program. He began reading the books Mentoring Center staff gave him and, for the first time, thinking about the impact of his actions on others. He had justified selling drugs by telling himself it was what he needed to do to keep his younger siblings fed. What, Mentoring Center leaders asked him, about the children of those whose addictions he was feeding? What were those children eating?

Michael graduated from the program still hesitant about the internal changes he was experiencing. "It was like putting on new shoes," he says. "You gotta break it in."

Like Curtis, Michael is fluent in Mentoring Center lingo – a collection of analogies and insights that guide young people through the psychological transformation the Center aims to facilitate. Most of his life, he realized, he had operated with tunnel vision; now he was gaining peripheral vision – learning to see beyond himself. "I never knew the grass was green," he says. "I never knew the sky was blue."

One evening in CYA, he was watching the television news and saw a story about a woman who had left a five-year-old child by the side of the freeway. The boy had been wandering along the side of the road when a trucker pulled over and carried him to safety. Michael couldn't stop thinking about the story.

"It was like a parallel of my life," he explains. "My mom left me out on the freeway and there was a lot of people that kept passing by and wanting to take me to safety, but I wasn't trying to hear that."

He woke up the next morning "a whole new person," determined to get on the next truck that came along.

The Mentoring Center was that truck. When he was released at 19, the Center paid Michael's rent for several months until he got on his feet. He enrolled in junior college and got a job at a shoe store. He took in his fifteen-year-old sister, who was still living with their mother. Mentoring Center staff stopped by periodically to check on the young household, and Michael spent time at the office when his busy schedule allowed.

While he was incarcerated, Michael had been evaluated by a psychologist and given the resulting report. He remembers only what he perceives as negative labels: Pessimistic. Reckless. Unable to trust.

Today, Michael has come to understand the behaviors that landed him behind bars as stemming from his anger towards his mother. "If you don't care about your mom, you're not going to really care about nobody else," he says. "That's how I felt."

He sees the mental health problems that are pervasive among juvenile offenders as rooted in trauma, and the resulting inability to trust. "Ninety-eight percent of the people that commit crimes just want to be heard," he says. "When you have somebody that's disconnected, and they don't feel like they're part of anything, it's easier for them to get in trouble. That's why the recidivism rate is so high."

That is also, says Michael, why programs that aim to support juvenile offenders as they transition to adulthood need to emphasize a personal connection. "Some organizations," he says, "you come in, they just tell you, 'Oh, we got the GED thing here, we got the pilot program there. Here's your bus pass.' But if you need to talk to someone, they don't have time."

The Mentoring Center has helped Michael with practical aspects of his transition – from housing to employment to college applications – but what he values most, he says, is the "personal connections. That has been the biggest thing for me not going back to prison. I feel like I'm a part of something."

LESSONS LEARNED FROM THE MENTORING CENTER

- Relationships that begin in one setting (e.g., juvenile prisons) and continue in the next (e.g., re-entry) provide crucial bridges.
- Survival needs and psychological needs are equally important.
- Transformations in thinking must accompany changes in behavior if those changes are to last.

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Youth Voice: Sherry

"They allowed me to be a child."

Sherry, 22, spent the years between 13 and 18 in a residential treatment center. She is now a working mother.

My mother was addicted to heroin for quite some time, and I couldn't deal with it. When I was 13, I told her I was having suicidal thoughts – not necessarily because I was, but because I wanted attention. She believed me and put me in a mental institution.

When it came time for me to be released, she was in jail because she was caught with heroin, so I went to the children's shelter. After that, I went to a residential treatment center, where I stayed until I was 18.

I've talked to a few people who say, "I hated the group home. I'm glad I'm out." But for me, it was a blessing. It really saved my life. I was fortunate enough to be in a place where people really cared about me and my well-being.

As a child, I never had a stable environment. I did not know from one day to the next if I was going to eat, or where I was going to live, or what man was going to be coming in today, and is he going to do this to me or is he going to do this to my mom?

At the residential treatment center, there was a routine. I knew that I was going to get up and go to school, and on certain days have therapy, and then come home and do homework and eat and go to bed. That was very calming. I felt like I could finally exhale.

At first, I wasn't open to therapy, because I wasn't used to needing help from anybody. I was very independent. My therapist never pushed, and never made me talk about anything I didn't want to, and eventually I came around. She kept everything very confidential and was never judgmental or condescending in any way.

The therapy that I received there let me know that the things that had happened were not my fault. I had felt for a long time that it was my job to save my mother and to get our life back to the way it was supposed to be. They helped me realize that I was not the mother, and I shouldn't have had to take on such a big responsibility at a young age. They allowed me to be a child, which I hadn't been for a very long time. I could cry, and I could make mistakes and it would be OK. I was thankful for that.

In therapy, I dealt with my fear of abandonment, exposure to drugs and alcohol, child molestation. It made me realize how strong a person I really was; that I had overcome a lot as a child. It also made me realize that there are people out there who care and do want to help you. I hadn't known it was like that.

Just the fact that somebody was willing to listen to me and be consistent meant a lot – especially since teenagers push buttons and test boundaries. Is this person for real? Is this person going to stick around? I tested it by saying mean things and calling my

therapist out of her name, or refusing to do any of the work she wanted me to do, and she still stuck with it. She never abandoned me, which is what my fear was. That became especially important when I was 15, when my mother, who suffered from depression, committed suicide. My therapist still stayed around.

Another thing that helped was being able to talk to people my age who were going through the same things I was. You don't feel like you are the only one anymore. We had group therapy every Tuesday, where I learned how to converse with people on a regular basis, and how to deal with issues that come up.

After I emancipated, the director of the center offered to see me in therapy. I was seeing her for a little bit, but I wanted to be independent, and I didn't like to burden people, so I stopped going to therapy. Looking back, I probably should have stayed with it. Recently I've realized that maybe I do need to seek some sort of therapy, or have some sort of medication again.

Emancipation was very scary for me. It was like you don't really have a choice. You can't say, "I want to stay here for a little while longer." The state says, "You're 18, you have to go." Once you're out there, everything that you used to have is all of a sudden gone.

I think it's really important to follow up with kids once they emancipate, and not take their support system right out from under them. It's difficult when you offer somebody something that's helpful for so many years and then just tell them, "OK, that's it, you're done."

I was very blessed [in being offered continuing therapy], and I know I didn't use it the way I could have. But I think it's important that we offer that to all of us. It's such a big shock when you have somebody to talk to for so long and then they just go away. It brings you right back to that abandonment issue.

You can't deal with kids who are having problems, who don't have their family, and then not follow up with them just because they emancipate. It takes a long time, the healing process. You have to feel like you're done – that you have closed those issues and you can move on. Otherwise you're going to end up right back at square one, and all those years of therapy are going to mean absolutely nothing.

Expert Insight: Kyra Bobinet, M.D.

"There is an inner experience of turmoil and trauma that must be addressed."

Kyra Bobinet, M.D. is the founder and executive director of Vision Youthz, a non-profit organization which works with young people at the Log Cabin Boys' Ranch and, post-release, in San Francisco. Bobinet, her staff and volunteers have developed an experiential therapy program that takes advantage of the hundreds of acres of forest that surround the ranch. They also use wilderness trips as part of their post-release support program.

When we were developing our approach, my co-founder and I spent a month in intensive, one-on-one alternative mental health sessions with young men at Log Cabin. We each saw three kids a day, for two hours each. Rain or shine, we were outside the whole time for each two-hour session.

One of the benefits of using nature and the earth is that you have an alternative environment that doesn't have the same stresses and pressures as the social environment in which these kids are locked. Many of them devote most of their energy to upholding their identity as a thug. They have shaped this way of protecting themselves from the threats around them. It took a lot of them a long time to take their shoes off and lay down on the ground without a blanket underneath them.

We did things like hopping over logs blind-folded. We did half-hour analyses on a little seed that we found on the ground, and related that to life. They all kept journals and wrote letters to themselves. If they didn't want to do that, we would do something experiential and metaphorical. If they were talking about how they were stressing, we might have them hang upside down in a tree.

Most of what we did with them was just asking questions, and using a lot of silence. Not filling the airspace – just allowing things to soften, to open. And just trying to be patient.

Asking questions stimulates curiosity. If you want to know something about the dirt, maybe you'll want to know something about why you feel the way you feel. It's a matter of getting used to opening your mind up to questions that you have, instead of shutting down.

Later, we began to do similar work with groups at Log Cabin. One exercise we've done is to say, "Go out and find something on the landscape that reminds you of something you're learning right now. Find yourself embodied in some object out there." Metaphor is a non-threatening way to open up conversations about things.

One day we went down to the creek with a group of young men and took off our shoes to stand in the water. When we started climbing back up the ravine, one of the kids stepped on a yellow jacket nest. The yellow jackets attacked everybody in sight.

There was such violence among the kids in response – "I want to hit and kill something right now!" It was that same place they had been to a million times, where they have been victimized, hurt, and they want to hurt something in return.

We sat in a circle and held hands. Some of the kids still had yellow jackets in their clothes, and they would be stung again and jump up. The kids were saying things like, "I was stung on my rear end – that's telling me to get up and do something with my life." Another said, "I got stung on my ear because the bee is telling me that I need to listen more." They saw that lessons come in many different forms – not always pleasant, comfortable ones.

Kids want healing. The way they're healing themselves right now, primarily, is self-medicating with marijuana. That, of course, interferes with their ability to maintain a job, get enrolled in school, or do other things that might benefit them. All of that is arrested by that emotional bolus. What makes what we do work is taking time with young people. The more injured young people are, the more individual time they need.

Beyond not going back to jail, beyond holding steady employment, there is an inner experience of turmoil and trauma that must be addressed. Current practices do little to unlock this tension, which exists in all humans but is amplified in these youth.

Time and again I have watched youth self-destruct from their unresolved grief, no matter what interesting job or education they had procured. Vision Youthz is using earth-based teachings, self-awareness tools and pattern recognition to empower young people to alter the course of their lives.

Case Study: A Home Within

RELATIONSHIPS BEGET RELATIONSHIPS

Psychotherapist Toni Heinemann was providing supervision at a San Francisco clinic when a young therapist in training came to her with a tough case. The trainee was seeing a child in foster care who was completely shut down in therapy, and she had found herself unable to break through.

Heinemann looked into the case and discovered that the boy had been through five different therapists – all trainees – in the past three years. That experience was, she learned, all too common. The reimbursement rates that the Department of Human Services was able to pay therapists were so low that most foster youth who were able to obtain therapy saw trainees – inexperienced clinicians who generally worked with them for less than a year before moving on.

"These were kids who had experienced loss," says Heinemann. "They needed continuous care, and they needed experienced therapists. There had to be a better way."

That better way developed over the course of the following ten years into A Home Within, which now provides individual therapy to 50 foster youth in San Francisco and another 100 elsewhere in the country. Home Within chapters currently operate in San Francisco, Alameda County, New York, Chicago, and Washington D.C. New chapters are in the works in Sacramento, Marin County, New York's Hudson River Valley, Miami, Boston and Los Angeles.

The Home Within premise is simple: Many foster care youth need and deserve consistent, high-quality psychotherapy to help them address the wounds they have suffered in their homes of origin and in foster care, and allow them to transition successfully to adulthood and independence. To that end, Heinemann recruits therapists in private practice who each volunteer to see a single patient. In return, the therapists receive group supervision from a senior practitioner.

Most people, Heinemann observes, develop a sense of self in the context of relationships – "you know that there is somebody who knew you when you were two, still knows you when you're 20, and will know you when you're 40."

Many foster youth lack that kind of touchstone. "One of the essential things about the foster care experience," says Heinemann, "is that nobody really has you in mind. Children learn who they are by having themselves reflected back by the parent. If the parent keeps changing, then how do you hold on to a consistent reflection of yourself?"

Because of how frequently many foster youth change placements, says Heinemann, "they bring to therapy the expectation that if they screw up, it's a seven-day notice." In that context, an important feature of therapy as practiced by A Home Within is that it has no time limit. A client can stay with the same therapist his whole life if he so chooses; already, some clients have spent a decade in care with the same practitioner. Heinemann

says she has learned to save every piece of art a child has made in her office; years later, when she pulls it out, it can give a young person an important sense of being known over time.

Another defining principle of the Home Within model is that the services offered are tailored to fit the individual – a premise that, while it might sound self-evident, is rarely observed in the economy of scale that is the foster care system. Home Within therapists will meet with parents – biological and/or foster – if they deem it clinically necessary, and may act as advocates within the school or child welfare systems to make sure their clients' needs are met.

Home Within therapists are acutely aware of the issues their clients will face upon emancipation, and aim to prepare them emotionally as well as practically for life on their own. Researchers have documented the many deficits with which young people leave the foster care system: they often lack housing, employment, health care, a high school degree and/or access to further education.[33]

NEEDS OF YOUNG PEOPLE LEAVING FOSTER CARE

- housing
- employment
- health care
- high school diploma
- access to education
- supportive relationships

Most profoundly, however, many lack abiding relationships. Having had their connection to their family of origin severed – and then, over and over, their connection to surrogate caretakers also severed – many feel profoundly alone, with little expectation that things will ever be otherwise. It is this fundamental void that A Home Within aims to address.

"Relationships beget relationships," notes Heinemann. "If you want to go from having bad relationships to having good ones, you need to have a good relationship – otherwise you don't know how to have one."

Through therapy, A Home Within aims to "give foster youth a relationship they can trust," says Heinemann. "But the therapeutic relationship is not an end in itself. The idea is that having this relationship allows them to move on and have other relationships."

"What they're lacking is a home to go home to," says Heinemann. "So they have to build a home within themselves that they carry with them."

PROFILE OF SUCCESS: MARTIN

Seven clinicians sit in Toni Heinemann's San Francisco office, a sunny room full of Legos, doll houses and thick psychiatric tomes. They are there to discuss seven kids.

As members of A Home Within's San Francisco chapter, each sees one child regularly, and also attends a weekly supervision with Heinemann. Today, a good deal of the group's attention is focused on therapist Claudette Heisler, whose 18-year-old client

Martin will leave his group home and enter college within a matter of weeks. Heisler has been seeing him for over a decade.

"Martin is going to Summerbridge (a week-long orientation program) but hasn't yet figured out how to get there," says Heisler somewhat wearily. "I asked him, 'Have you packed? Do you have toothpaste?' He laughed. He hadn't thought about those things."

"One thing we struggle with," Heinemann observes in response, "is where therapy ends and parenting begins. If you're saying, 'Have you packed?' it's not therapy, but it's what he needs. It's our job as parents to hold the anxieties so they, as adolescents, can take all the risks."

A few weeks later, Martin emerges from Heisler's office wearing a sweatshirt bearing the name of the university where he will soon enroll as a freshman, and a backpack so new the tags are hanging off it. He did in fact make it to Summerbridge – presumably with toothpaste in hand – and has now moved into an apartment near campus with two sophomores he met at the orientation program.

Martin has applied for financial aid but will not receive his first check for several weeks. He moved out of his group home a few days earlier, and, for the time being, has no money for food. Heisler tells him to fill his backpack with snacks from a cupboard in her office. Somewhat sheepishly, he complies.

Martin was three years old when his parents, who used drugs, lost custody of him and he went to live with his grandmother. At 11, when his grandmother decided she could no longer handle him, he entered foster care.

By Martin's account, he entered therapy as a child because "when I was little, I was very bad." In elementary school, he would overturn desks, threaten teachers and hit other children.

At first, he simply saw his sessions with Heisler as "fun" – he got to skip class, play games, and have someone's undivided attention. As he went on to ten placements in seven years, those sessions became an important constant in an otherwise tumultuous life.

"Claudette has been reliable," says Martin. "She has always been there to talk to. If I was angry about something, she would help me understand why. Before, if I got mad, I wouldn't look into it – I just got mad. She made me look at the real reason behind me getting mad, and that helped me out."

Martin believes his anger is what led his grandmother to place him in foster care, and then led a succession of foster and group homes to send him on his way. At one point he wound up in a residential treatment center, where his outbursts earned him time in a "quiet room" – a padded room where he would rage at the top of his lungs, then pound the walls until he fell asleep.

Today, Martin sees his childhood outbursts as a reaction to "the setting I was faced with growing up, like my mom and dad doing drugs." At the time, all he knew was that he

could not make himself stop. Through understanding his anger, he says, he has also learned to control it; to find outlets other than destruction.

While Martin refers frequently to the progress he has made in controlling his anger, Heisler cites other therapeutic priorities. “A lot of therapies are oriented towards teaching kids different behaviors,” she notes. “I think a therapy that focuses on building relationships is particularly essential with foster kids.”

Heisler – like many who work successfully with young people in the foster care and juvenile justice systems – recognizes the need to offer practical as well as emotional support. “If there’s no stability in a kid’s life,” she observes, “how can you attend to things that feel a little less pressing – like building relationships?”

When Martin’s house burned down when he was in the third grade, Heisler began visiting his grandmother, who had sunk into a depression, and arranged for his school to host a fundraising drive for the family. When he was unhappy after being transferred to a new school in the sixth grade, she got him moved back to his old school. When he was ready to attend high school, she and a teacher arranged for him to be admitted to a private school, where he could receive extra attention and support, as well as a college preparatory education. As he heads off to college, she has arranged for a mentor to support him in that transition.

Despite these efforts, Heisler recognizes that Martin is faced with a tremendous vacuum in his life. His father lives in another state, with a second family. Martin has seen his father only a few times in his life, and has never met his half-siblings.

His mother lives nearby and he visits her occasionally. “We laugh, and have fun, and I can see I have characteristics of her,” he says, “but in some ways she still hasn’t changed. I gave her a ticket to my high school graduation, and she said she was going to come, but she didn’t.”

“One question that comes to my mind,” says Heisler, “is whether a therapy relationship is adequate, especially once a week, in terms of compensating for the day-to-day intensity of a parent/child relationship.”

It is a question Martin might not be able to answer – or even to ask – but he does recognize that as his home and caretakers changed over and over, Heisler has always been there. He would take the bus to her office each week, or she would pick him up and take him out to eat. Sometimes he was embarrassed about going to therapy – people might think he was crazy. He went anyway.

At the beginning, Martin remembers playing Connect Four. When he hit adolescence, his conversations with Heisler deepened. He began talking about his family. Heisler helped him manage conflicts at school and in his various homes.

As Martin heads off to college – where, for the first time, he will not see Heisler on a weekly basis – both Heisler and her colleagues worry about him.

Heinemann recalls a friend whose son recently called from college and asked, “Where do you buy safety pins?” His mother, predictably, sent the pins herself.

“That’s what we think over and over with Martin,” Heinemann says. “Who is he going to call and say, ‘Where do you buy safety pins?’”

PROFILE OF SUCCESS: CARLA

If you had asked Carla at 18 whether she thought she needed a therapist, she might have laughed out loud – or worse. A veteran of multiple foster homes, group homes, juvenile detention centers and psychiatric hospitals, Carla learned from her experience to avoid mental health services – and the attendant stigma—at all cost.

Carla was sent to psychiatric hospitals several times during her journey through the foster care system. She was hospitalized, in her view, “if I’d get crazy or I needed some help or attention. I’d have like a nervous breakdown and start screaming and yelling. It’s really obvious you need some attention, and somebody to stop you and be like, ‘Give me a hug,’ you know?”

“The mental hospitals reaffirmed that nobody liked me!” shouts Carla, now 23. “If anybody liked me, they wouldn’t have let me be there.”

“People do that,” she continues – “people yell and scream and throw things, especially people who are in foster care and group homes who have been through stuff. The mental hospital was like a trick. They were supposed to help heal you, but really they just lock you up. It’s like a psychological jail.”

Carla’s first trip to a psychiatric hospital came at age 12, after she told someone in her group home that she planned to commit suicide. She says hospital staff determined that she was lying (she was) and sent her back home. Later on, she broke into the office at the group home and read her own file. The report from the hospital described her as a sullen, overweight child who was wearing shorts even though it was cold outside. More than ten years later, those offhand words still wound her. She knew she was not meant to see them – and even understands that they may have been more descriptive than derogatory – but the knowledge that her arrival at each new home would be preceded by a file containing that less-than-flattering description made her wary and defensive, both of the profession that had produced the evaluation and the individuals who had access to it.

A few years later, Carla was placed in a residential treatment center in another state. When staff took away her CD collection because they deemed the content inappropriate, she responded with an angry outburst that again landed her in a psychiatric hospital. She stayed three months while social workers tried to find another placement for her. She doesn’t remember much interaction with hospital staff, but found the stay a soothing respite. Her CDs were returned to her, and she was given books, crayons and a room of her own.

"I didn't have to relate to anyone," she recalls, "and I was really tired of relating to everybody. So I was actually grateful for a quiet room alone."

Her next trip to the hospital provided no such solace. By then, she was living in yet another group home. One afternoon she left the house and ran down the street, screaming and crying. Police picked her up and took her, once again, to a psychiatric hospital.

At the hospital, Carla continued to vent her pain through escape attempts and angry outbursts, which resulted only in the humiliating experience of finding herself strapped to a table. Once, she broke free of the restraints and carved her initials into the ceiling "to prove to them I had an unconquerable spirit." What she did not do was disclose, or explore, the sources of her anger.

"They obviously weren't asking the right questions," Carla says now. "Mental hospitals are not just for people with mental illness. They're for people who are somehow hurt, and they treat you like you have a mental illness. It's like they're saying it's not OK to hurt – that it's an illness. But sometimes if you just go ahead and let somebody be crazy and love them through it, that's how they get better."

At 23, Carla is finding getting better an ongoing process – a process of which A Home Within has become an important part.

Carla was 22 when a friend referred her to the program, which is open to emancipated foster youth as well as those still in care. She went, she says, "because I wanted some undivided attention."

The fact that she had walked in the door voluntarily helped Carla open herself to a process she had reason to fear. Because she knew she could walk out again without fear of consequence, she didn't. A year later, she feels she is only beginning to reap the benefits of her relationship with Home Within clinician Diane Ehrensahft.

"I don't know you yet," Ehrensahft has said to her. For someone who has been labeled and diagnosed as much as Carla has – who has encountered any number of helping professionals who felt they understood her because they had read her file – that simple admission granted her license to begin to explore, to get to know, herself.

A bright and ambitious young woman, Carla has, through therapy, come to see how her emotional volatility has kept her from reaching goals such as finishing college and securing stable work.

"It's nice to have someone put their finger on your emotional pulse," she says – "'Do you have highs and lows?' Someone actually cares about the pattern that you're establishing, and how your mood changes affect your productivity. She helps make me aware of my own patterns, to give me more self-awareness."

"Therapy can be conversations with yourself," Carla says. "But there is something to be said for the sight of another person."

The fact that, in this instance, that other person is a highly trained professional with a private practice and a well-appointed office makes a difference to Carla, who enjoys feeling "like a yuppie" as she rushes off to her afternoon therapy appointment.

"Everyone knows therapy is like $100 an hour," she says proudly. "If you can afford therapy, it says something about your status and prestige. If you're getting it free, it's like saying you're special. It's a lot different from being put in a mental hospital."

In therapy, Carla says, she is finding a sense of unconditional acceptance that foster youth – whose experience has often taught them that "acting out" leads to packing one's bags – find hard to come by.

"It's like Jerry Springer!" she jokes. "You can admit to all the messed up things you did and your therapist still loves you."

This sense of acceptance is only the first step. Carla's hope now is to use the therapeutic process to deal with the emotional and psychological issues that she has come to see as impeding her ability to stabilize her life and move forward with her goals.

"Now I have someone following my patterns; helping me to organize my thoughts," she says. "Organization begins within. Right now I'm hella disorganized. I don't even have a date book. Can you imagine what happens when I get organized and have a date book? Boy, I'm outta here!"

Lessons Learned from A Home Within

- Those with the greatest needs deserve the highest quality care.
- Young people who have experienced repeated abandonment need relationships that last.
- Young people must have their practical needs attended to along with their mental health needs.
- Care should be tailored to the individual.

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Youth Voice: Marina

"It's just you and whatever you're doing."

Marina, 21, entered foster care in her early teens, and spent the following years in group homes and juvenile hall.

My first psychiatric experience was when I was 11. I had been molested by a relative, and I had a lot of problems from that. My mother and I were staying in a shelter and I tried to jump off the roof. They took me to the hospital, where they diagnosed me with clinical depression.

Being in the hospital was a helpful experience when I was younger. The counselors helped out a lot, and the group activities. Other than that, they had me on Prozac, and I didn't too much like that. I remember feeling sick and dizzy, and going to sleep all the time.

After the hospital, me and my mother used to get in arguments all the time about the molestation thing. She never believed me, and it seemed like she grew a little colder to me for some reason, and I didn't know why.

By the time I was on my way to adolescence, I got fed up and started drinking and stuff. You try to drink to dull stuff away, but it ended up making it worse. I just kept feeling all down and suicidal, writing this little dark poetry.

Every time I got into it with my mother, it would be, "I'm fed up with you. Let me call the police and they'll take you to the psychiatric hospital." After I'd leave the hospital I'd be on meds, but there was no counseling or anything like that.

After a while I started going back and forth to group homes. At the group home they keep your meds in a locked box, and they make you take them on a set schedule. I was taking Prozac and Ativan, but then I would go out and drink and smoke weed. The meds intensified the alcohol.

I picked up probation when I was 16 or 17. I was in a group home and my friends and I took my friend's mother's car and ran into a garage. We were drunk. After that I was in and out of juvenile hall for probation violations, like AWOLing from the group home.

In juvenile hall, they don't really help you [with mental health]. Actually, they diagnose you. They set me in a room by myself with a big old stack of test papers and made me draw pictures and look at the little inkblots. I didn't hear the results until court. They said I was paranoid and clinically depressed.

I was offered counseling at one point when I was in the group home. She was a really nice lady, but it wasn't working out! She was more like a baby counselor. She tried to do the doll things, the toys, and I was 16. I didn't want to play with dolls! She did everything she could do to get me to open up, but I felt like holding it in was better. I quit going after about three months.

I was in juvenile hall when I found out I was pregnant. After I got out, we got on aid for a year while I was still in school. Then I decided to work so I could pay for everything.

My son is two now. I feel like I'm over being depressed. When I was a kid, I wasn't really able to rely on myself. But I've learned that when it comes down to it, it's just you and whatever you're doing. I have to be self-reliant if I want to survive, and have my son survive.

It came down to two choices. Do you want to be a productive member of society, or do you want to seclude yourself from everybody and be all depressed and stuff? What do you want to do? You going to let your problems stick on you forever?

My son helped a lot. That's one thing I can say about having my son at a young age – he was my motivation. Everything I do – trying to improve myself – I'm pretty much doing for him. He needs somebody that's going to be there, not some crazy old biddy locked up in a psychiatric facility all the time.

Expert Insight: Margaret Norris

"By expressing his anger, he was able to stop acting on it."

Some of the young people who attend Margaret Norris' Tuesday night class at San Francisco's Omega Boys' Club – which works with young men and women in and out of juvenile hall and CYA facilities – will tell you that it feels like church. Others call it therapy. "Ms. Norris," as she is universally known, has a background in education and a gift for what she has come to see as the treatment of psychic wounds that, left unhealed, can contribute to violence and criminality.

The first thing I do in helping people deal with their anger, fear and pain is show them a mirror. It's a means to get in there – to get into the emotions of an individual, break down that wall.

I'll have them read books, or watch movies, about people who have dealt with situations similar to theirs. As they begin to identify different mistakes the character or person has made in terms of choices, I gradually replace the character with the student. That way it's not threatening. And I do not allow them to assassinate the character of anyone they may read about in a novel or learn about in history. That creates a safety net where they know I won't allow anyone to assassinate their character as they begin to divulge their own truth.

During one class, we watched the movie "Sugar Hill," with Wesley Snipes playing a drug dealer. The opening scene goes back to his childhood, when he and his little brother were in a room with their mother, a heroin addict. She was telling them to tie her on so she could get her shot of heroin. One young man leapt out of the classroom in a rage. Little did I know I was showing him the mirror of his own mother, himself and his brother.

For the next assignment, the students had to write letters to their mothers for Mother's Day – everything they'd never been able to say. When this young man wrote that letter, that's when the anger started to crack, and he was able to get out of his system all this pent-up anger that he had been feeling for years. The dam broke, and from that point on he was working hard to deal with all the things that brought him pain, and not to repeat painful actions by taking them out on someone else. By expressing his anger, he was able to stop acting on it.

To reach that point with a young person, you have to be willing to stay with him in the face of his anger. If you don't think you can handle it, then be prepared to pass on to someone who can, but we can't leave our children hanging. That's like opening a wound in surgery and not being able to sew it up – the patient will get an infection. At the Omega Boys Club, we each perform several functions, so the kids always have somebody to fall back on. They know they've got us and we're not going to go away.

Overall Lessons

Following are lessons that can be drawn from the experiences of the young people who shared their stories and from those who are working with them on the front lines:

- **First, do no harm.** The best mental health care in the world is no substitute for prevention. The systems charged with caring for young people must commit themselves to providing environments that heal, rather than exacerbate or cause, mental health problems.

- **Acknowledge trauma; avoid stigma.** Care that starts from the premise that a young person has been hurt and needs help healing will be better received than that which starts from the premise (however unspoken) that he is broken and needs fixing.

- **Relationships heal.** Young people who are relationship-starved and have experienced betrayal seek out connection but test for authenticity. In this context, short-term therapeutic relationships are less likely to be productive than long-term care from adults who are available on a consistent basis.

- **Fix the situation, not just the kid.** Vulnerable young people struggling to gain footing as adults will almost always tell you that survival needs come first. Treating a homeless kid for anxiety is not enough; his anxiety is unlikely to abate until he also has a roof over his head. A hungry kid needs a meal before he can have a conversation. The approaches vulnerable young adults value most combine practical assistance with mental health care.

- **More of the usual may not work.** There is much in the experience of young people coming out of the foster care and juvenile justice systems to predispose them to reject conventional mental health approaches. Approaches that recognize and work with and around these concerns may have a better chance of success than those that were devised for clients who have not had these experiences.

- **Make meds make sense.** Young people whose families have been impacted by drug use may be inclined to reject even needed psychotropic medications as just another dangerous drug. Those young people for whom medication is indicated need culturally sensitive counseling to help them understand what medication they are being given, why it will help them and what to expect in the way of both side effects and improvements. When they exit the foster care or juvenile justice systems, or individual placements, provision must be made for ongoing medical care so they are not forced abruptly to discontinue their medication.

- **Marry youth development to mental health care.** Many young people describe interventions that fall under the rubric of youth development – mentoring, youth arts, etc. – as having had a therapeutic effect. At the same time, staff at youth development programs whose constituencies include those coming out of the foster care and juvenile justice systems cite the need for professional mental health services to help them meet the needs of their most vulnerable and traumatized clientele.

Increased collaboration between the youth development and mental health communities could go a long way towards meeting the needs of the young people both aim to serve.

- **Provide confidentiality to the degree possible – and when it is not possible, make that clear up front.** The expectation of privacy is central to the therapeutic process. Young people who feel their confidentiality has been violated will become increasingly mistrustful of offers of help.

- **Offer young people a voice in treatment decisions.** Young people are the experts on their own needs. Offering them a say in their treatment will produce valuable insights, as well as encouraging participation.

Appendix – Survey Questions

The following questions were used to gather information from youth in the foster care and juvenile justice systems.

Thank you very much for taking the time to answer these questions. The goal is to find out what your experience has been with mental health care, and to get your ideas about what kind of care or support you feel would help you the most (if any). Feel free to use the attached blank pages if you need more space. And thanks again for your time and your thoughts.

1) How old are you?

2) Are you male/female? (please circle one)

3) How long have you spent in foster care? How many placements have you been in? [Alternate questions: Have you been in CYA or juvenile hall before? If yes, how many times?]

4) How would you define "mental health"? What do those words mean to you?

5) Do you consider yourself mentally healthy, whatever that means to you? Why or why not?

6) What has most helped you remain mentally healthy in your life?

7) Have you ever been to see a therapist? (if no, skip to question 15)

8) Who decided you needed to see a therapist, and why? Did you choose to go or were you told to go?

9) For how long did you see the therapist, and how often? (once a week, once a month, etc.)

10) What was the best part about seeing a therapist?

11) What was the worst part?

12) What do you wish your therapist had done but didn't?

13) Have you ever been given a psychiatric diagnosis or label, or been told you had an emotional problem? (If no, skip to question 16)

14) What was it and who talked to you about it?

15) How did that make you feel?

16) Have you ever received medication for a mental health issue or emotional problem--for example, anti-depressant, anti-anxiety? (If no, skip to question 20)

17) What was the medication and how long did you take it?

18) Were you told about how it was supposed to help and what side effects it might cause?

19) How did it make you feel? Do you feel it helped you?

20) Have you ever spent time in a psychiatric hospital/residential treatment center? (If yes, please circle which one. If no, skip to essay question at the end).

21) Why were you there, and for how long?

22) Do you feel the experience helped you? Why or why not?

Essay question: (optional)

Imagine you are in charge. It is your job to support the "mental health"--whatever that means to you--of a young person who has been through hard times in his or her life. What would you do, say, offer or suggest?

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