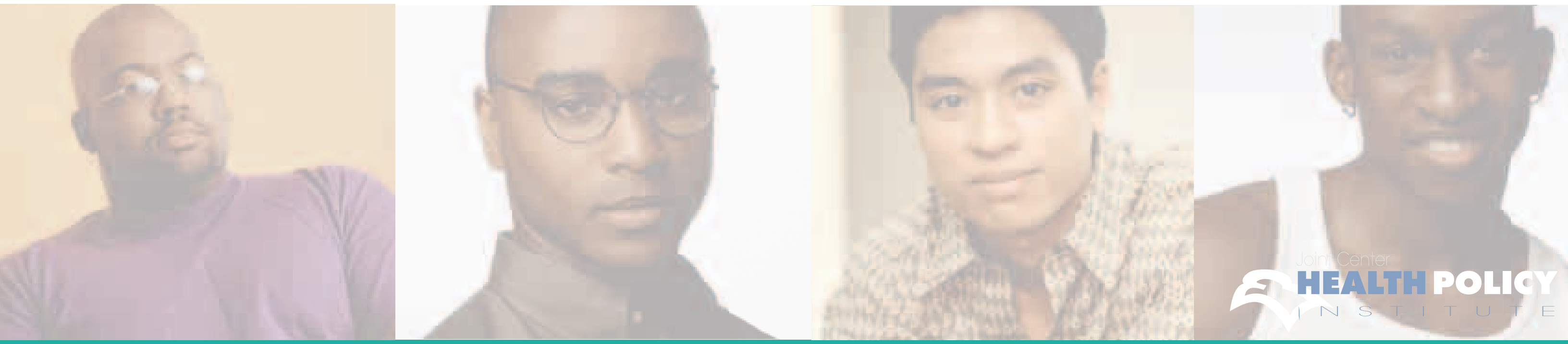
BACKGROUND PAPER
THE JOINT CENTER HEALTH POLICY INSTITUTE

COMMUNITY HEALTH STRATEGIES TO BETTER THE LIFE OPTIONS OF BOYS AND YOUNG MEN OF COLOR: POLICY ISSUES AND SOLUTIONS

KAY RANDOLPH-BACK



DELLUMS COMMISSION

BETTER HEALTH THROUGH
STRONGER COMMUNITIES:
PUBLIC POLICY REFORM TO
EXPAND LIFE PATHS OF YOUNG
MEN OF COLOR

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KAY RANDOLPH-BACK

JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES
HEALTH POLICY INSTITUTE

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PREFACE

During the past twenty-five years, a series of public policies have had a negative impact upon young men from communities of color. These policies, which have been enacted and often amended incrementally, are numerous. They include the abandonment of rehabilitation and treatment for drug users in favor of interdiction and criminal sanctions in the 1980s, state policies to divert youthful offenders to adult criminal systems, and the imposition of zero-tolerance policies to exclude youth with problems from public schools in the 1990s. These policies have had a cumulative and hardening effect of limiting life options for young men of color. High school dropout rates and declining enrollment in postsecondary education, at the same time that rates of incarceration increase, are explained, to a significant degree, by these policies.

The Dellums Commission, chaired by former Congressman and Mayor-elect Ronald V. Dellums, was formed by the Health Policy Institute of the Joint Center for Political and Economic Studies to analyze policies that affect the physical, emotional, and social health of young men of color and their communities and to develop an action plan to alter those public policies that limit life paths for young men of color. To understand the issues more fully and to inform its deliberations in formulating an ambitious but realistic action plan, the Dellums Commission asked experts in various fields to prepare background papers on specific issues. These background papers serve to inform the Dellums Commission's recommendations.

This background paper focuses on health strategies to protect the health of boys and young men of color. It encompasses five major issue areas: (1) access to community-based services for health promotion, primary and secondary prevention, early intervention, and treatment; (2) outreach and enrollment in publicly supported health care coverage programs; (3) mental health and substance abuse services: integration of physical health promotion and care with behavioral health promotion and care; (4) access to health care professionals and services (including mental health) that reflect the cultural and racial composition of the community; and (5) access to high quality physical and behavioral health services within the criminal justice, juvenile justice, and foster care systems. The author offers an extensive discussion of each topic as well as recommendations for policymakers. This paper complements and reinforces the conclusions of other Dellums Commission background papers on education, health, criminal and juvenile justice, recidivism, the child welfare system, the media, and community well-being.

The work of the Dellums Commission is part of a larger effort by the Joint Center Health Policy Institute (HPI), which is funded by the W. K. Kellogg Foundation. HPI's mission is to ignite a "Fair Health" movement that gives people of color the inalienable right to equal opportunity for healthy lives. In igniting such a movement, HPI seeks to help communities of color identify short- and long-term policy objectives and related activities that:

- Address the economic, social, environmental, and behavioral determinants of health;
- Allocate resources for the prevention and effective treatment of chronic illness;
- Reduce infant mortality and improve child and maternal health;
- Reduce risk factors and support healthy behaviors among children and youth;
- Improve mental health and reduce factors that promote violence;
- Optimize access to quality health care; and
- Create conditions for healthy aging and the improvement of the quality of life for seniors.

We are grateful to Kay Randolph-Back for preparing this paper and to those Joint Center staff members who have contributed to the work of the Health Policy Institute and to the preparation, editing, design, and publication of this paper and the other background papers. Most of all, we are grateful to Mayor-elect Dellums, the members of the Commission, and Dr. Gail Christopher, Joint Center vice president for health, women and families, for their dedication and commitment to improving life options for young men of color across the United States.

Margaret C. Simms
Interim President and CEO
Joint Center for Political and Economic Studies

INTRODUCTION

Investment in the health of young minority males is investment in their futures and the nation's future. Theirs is the period of life for taking risks and forming habits that go far in determining the future of personal health and productivity, the quality and length of life, and the cause of death, whether premature or coming in the fullness of time. Young minority males deserve a comprehensive investment strategy that recognizes their uniqueness and value, the challenges they face, and the disproportionate burden they bear in health risks and health problems. However, instead of promoting health and healthy development, too many public policies and practices today are creating environments that are inimical to health. They tell the young minority male, "You are not worthy. You do not count." While minority health, men's health, and the health of adolescents and young adults have all gained places on public policy agendas, boys and young men of color, not fitting neatly into any one of these categories, remain marginalized. Society sends powerful messages when it designs health services for others, but not for young minority males; screens others for conditions that kill and maim, but not young minority males; and offers health care coverage for others, but not for young minority males. These crippling messages devalue being a boy or young man of color.

A vision of health protection for young minority males inspires the exploration of issues and the recommendations in this paper. It is a vision in which boys and young men of color are valued and their health is promoted—by their families and communities; by institutional and public policymakers; and, just as importantly, by themselves, as assets for their own better health and that of their peers and communities.

What investments in young minority males must state governments make in order to achieve that vision of health protection? This paper was written to help the Dellums Commission answer that question. The Commission chose 10 jurisdictions for special attention: California, Washington, D.C., Florida, Georgia, Illinois, Maryland, Mississippi, New Mexico, New York, and Texas. The Commission also chose issues and themes that helped shape this paper.

The paper is divided into five parts, one for each of the major issue areas. At the conclusion of each part, the paper offers the Commission—and all advocates for young minority males—proposed recommendations for consideration. The following are the five areas the paper explores:

Part I: Access to Community-Based Services for Health Promotion, Primary and Secondary Prevention, Early Intervention, and Treatment

Part II: Outreach and Enrollment in Publicly Supported Health Care Coverage Programs

Part III: Mental Health and Substance Abuse Services: Integration of Physical Health Promotion and Care with Behavioral Health Promotion and Care

Part IV: Access to Health Care Professionals and Services (Including Mental Health) That Reflect the Cultural and Racial Composition of the Community

Part V: Access to High Quality Physical and Behavioral Health Services within the Criminal Justice, Juvenile Justice, and Foster Care Systems

PART I: ACCESS TO COMMUNITY-BASED SERVICES FOR HEALTH PROMOTION, PRIMARY AND SECONDARY PREVENTION, EARLY INTERVENTION, AND TREATMENT

The discussion of this topic is divided into four sections. First, the stage is set for talking about services by laying out facts concerning young minority males' priority health problems. Next, the implications those facts have for actions that may be taken are analyzed in the context of what is now going on in the field. The primary implication is that the nature of the risks and conditions they face makes it necessary to offer a continuum of services and strategies. The continuum ranges across medical care, public health, youth development, and community development. The field has made much progress in defining a continuum for adolescents and young adults in general, but work remains to be done in defining the continuum from the perspective of boys and young men of color. The third section then homes in on key features of the continuum that advocates for boys and young men of color could stress. The concluding section recommends changes in policy and practice.

What are the Priority Health Problems of Boys and Young Men of Color for Health Services to Address? Facts to Set the Stage for Discussion

What are the priority health needs and issues for male youth of color that the design of services should take into account? A new profile of males *ages 10 - 24* released in November 2005 by the National Adolescent Health Information Center is a useful guide. *A Health Profile of Adolescent and Young Males: 2005 Brief*[1] (hereinafter called *Profile*) was written with support from the Office of Adolescent Health in the Maternal and Child Health Bureau of the Health Resources and Services Administration. Facts from this profile are summarized here. In reviewing these facts, the reader should note that *the fields of health, human services, and education do not make it a practice to consistently break down data by age, race/*

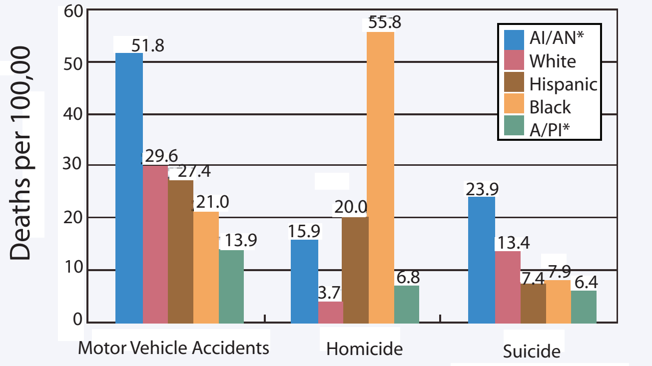
ethnicity, and gender at the same time. It is not uncommon when researching these fields to find data cut or disaggregated by any two of the three categories but not by the remaining one. For example, when reporting on a health problem for the age group, the profile summarized here does not always give race/ethnicity for the boys and young men.

Profile sets the stage for discussing young men's critical health issues with the following points:

- major physical, mental, and psychosocial changes occur during this stage of life;
- people in this age group have growing independence to make health-related choices;
- the "transition differs for young men and women";[2]
- 21 of the federal government's *Healthy People 2010* objectives are critical for this age group (as discussed further below); and
- racial and ethnic diversity in the age group—which was nearly 38 percent non-white in 2000—will continue to grow.

Profile then turns to the mortality rates for males in the age group. The good news is that the rates are at record lows. However, their death rates for the main killers—motor vehicle accidents, homicide, and suicide—are higher than for females. Further, within their death rates the racial and ethnic disparities are large. *Profile* shows them as follows:

Figure 1: Mortality Rates by Cause and Race/Ethnicity, Males, Ages 10-24, 2002



Source: NCIPC, 2005

* AI/AN refers to American Indian and Alaska Native; A/PI refers to Asian/Pacific Islander

Homicide: Over the nine years from 1993 to 2002, the homicide rates for males aged 10-24 fell, most sharply for blacks (from 114.3 per 100,000 population in 1993 to the rate of 55.8 shown in the figure). According to self-reporting on behavioral risks in 2003, males in high school are much more likely to get into physical fights, carry weapons, and carry guns than female students. The racial and ethnic differences among males for these behaviors are not large.

Substance Abuse: In general, the level of substance abuse is now lower than the record levels reached in the late 1970s and early 1980s. Persons 18-25 have higher rates than those who are 12-17. Overall, self-reported substance use rates are highest among whites and American Indians/Alaskan Natives. While higher percentages of males than females aged 18-25 smoke, drink heavily or use illicit drugs, the gender disparities that stand out are for heavy drinking; in 2003, heavy alcohol use was engaged in by 21.2 percent of males vs. 9 percent of females; and binge drinking, by 51.6 percent of males vs. 32.2 percent of females). Among males, rates for heavy drinking are highest for whites; rates for smoking are highest for American Indians/Alaskan Natives (56.1 percent) and whites (48 percent); and rates for using marijuana are highest for American Indians/Alaskan Natives (32.4 percent) and lowest for blacks (21.9 percent). Among adolescents, using drugs goes together with smoking or heavy drinking, that is, smokers or drinkers are much more likely to use drugs than non-smokers and non-drinkers ages 12-17. While rates of drug abuse by both genders go down after age 25, there are serious issues for the 18-25 group, where use is most common among American Indians/Alaskan Natives. As males move from the 12-to-17 age category to the 18-to-25 category, their use of, or dependence on, alcohol or illicit drugs rises from 8.7 percent to 26.3 percent, while the comparable rates for females rise from 9.1 percent to 15.7 percent. Thus, the rise in use of these substances from adolescence to young adulthood is much steeper for males than females. *Profile* links limiting substance abuse to promoting mental health.

Mental Health and Mental Disabilities: About 75 percent of mental health disorders in the U.S. population manifest by the age of 24. Suicide rates for males ages 10-24 have fallen from highs in the early 1990s, but they are nevertheless three times higher than females' rates in early adolescence and nearly seven times higher in young adulthood. Further, while high school girls experience more depression and persistent sadness than boys, "[m]ore males than females ages 10-24 report outpatient visits for mental health disorders (1.9 million vs. 1.6 million in 2002)."[3] Even though their rates are lower, depression still hurts high school boys: one in 17 "is depressed and one in five experiences sadness and hopelessness that interferes with their lives."[4] In the 12-17 age group, 12.1 percent of males have attention deficit hyperactivity disorder compared to 4.3 percent of females and 12.8 percent have learning disabilities compared to 7.1 percent of females.

"Learning disabilities are associated with a range of negative outcomes including increased violent behavior, juvenile delinquency, and suicide attempts."[5]

Before continuing this summary of the findings in *Profile*, it is worthwhile to comment on the above reported association between learning disabilities and negative outcomes. *State Public Education Policy and Life Pathways for Boys and Young Men of Color*,[6] a paper written for advocates for young minority males, reports on expert opinion that some cases labeled ADD/ADHD[*] (or sought to be so labeled by school districts) would better be attributed to the effect of the traditional educational process on boys than to a diagnosable condition often treated with Ritalin. According to this expert opinion, different styles of teaching or single-sex education may be preferable alternatives to medication for some boys. Another phenomenon seen in the field is that boys who are hard to handle may be designated for special education in order to move them, their balkiness, and their low standardized test scores out of the regular classroom. One source of their misbehavior may be "acting out" that is due to their being expected to read when they haven't been taught to read. A learning disability might, then, also be "associated," to use *Profile*'s term, with a school's difficulty handling its responsibilities rather than with a boy's actual ability to learn.[†] (However, schools may also disfavor labeling because special education students have more protection against expulsion and suspension.) In contrast to the statement quoted above from *Profile*, might it be said from another perspective that learning disabilities and the phenomena with which they are associated—violent behavior, juvenile delinquency, and suicide attempts—can all be regarded as negative outcomes to which unsuitable schooling that is unresponsive to gender and cultural differences contributes?

While 10.3 percent of young adult males ages 18-25 have diagnosable serious mental illnesses, 17 percent of females do. Thirty-five percent of young adults with such problems receive treatment or counseling. Racial or ethnic disparities in mental illness within the age group are fairly small.

Sexually Transmitted Infections: Although the rate of sexual activity among high schoolers has declined in the last decade, by 12th grade more than 80 percent of blacks, more than 60 percent of Hispanics, and more than 50 percent of whites are sexually experienced. Among other things, this means that the risk of sexually transmitted infections is significant, even with condom use rising to 68.8 percent for high school males in 2003 and 57.4 percent for high school females (compared to 54.5 percent and 38 percent, respectively, in 1991). Late adolescence and young adulthood are peak times for sexually transmitted infections. The risk of infection is augmented by the fact that about three-quarters of sexually active, single young men ages 18-26 have unprotected sexual intercourse. While syphilis and gonorrhea are trending downward, chlamydia rates have risen, perhaps partly from better testing and reporting. Chlamydia rates are much lower for males, than females, but among males blacks are disproportionately affected. The gravest risk is, of course, contracting HIV/AIDS. "In 2002, Black males comprised a third (32.2 percent) of new HIV/AIDS cases among young adults ages 20-24 and Black females comprised another 25 percent."[7]

Obesity: *Profile* next turns to two vital pediatric antecedents of adult chronic disease: obesity and physical inactivity. Obesity has tripled among adolescents in the last quarter century and has been demonstrated to be a precursor of adult obesity. While there are no major differences between the overall obesity rates of male and female adolescents (16.7 percent male vs. 15.4 percent female) or young adults ages 24-26 (16.8 percent male vs. 17.2 percent female), among adolescents there are important racial/ethnic and gender disparities. Whites have the lowest rates in the group. Among blacks the rate for males is 18.7 percent, for females, 23.6 percent; among Mexican-Americans (the term used by *Profile*) the rate for males is 24.7 percent, for females, 19.9 percent. *Profile* gives physical activity rates for male and female 12th graders (66.1 percent vs. 45.5 percent) and male and female young adults ages 24-26 (48.1 percent vs. 33.2 percent).

Health Coverage: *Profile* also briefs the issues in health care access and utilization. Between 1995 and 2002, Medicaid expansions and the State Children's Health Insurance Program (SCHIP) helped lower the rate of uninsurance among 10- to 18-year-olds, which fell from 14.1 percent to 12.2 percent. Eligibility for public coverage or coverage under parents' private insurance generally ends in late adolescence or early adulthood. Females may fare better due to Medicaid's coverage of low-income families, which are often single-parent households headed by young women. The uninsurance rate for young adult males is 33 percent, for females, 27 percent. Rates are higher for young adults who are poor or Hispanic or not full-time students. Disparities in access and utilization are found between insured and uninsured young adults.

Health Care Access and Utilization: Barriers to access to oral health services left 18.6 percent of adolescents without a dental visit in the year prior to collection of the data and 7.3 percent with unmet dental need. For other types of services, disparities between males and females are reported:

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[*] ADD is the acronym for attention deficit disorder. ADHD is the acronym for attention deficit hyperactivity disorder.

[†] See also the following statement by a youth (quoted below under section V in the part on the foster care system) directed toward judges who review foster care cases: "Make sure I am in Special Ed. for a reason … other than just because I am in foster care. Not all of us are behind or slow–and if we are, try offering us tutoring rather than putting us in special classes."

Young adult males are much more likely than females to report no contact with a health professional (35.1 percent vs. 12.8 percent) and no usual source of care (36.3 percent vs. 19.9 percent). Females are slightly more likely to report not filling a prescription (9.0 percent vs. 5.7 percent). Males and females report similar rates of foregoing care (11.1 percent vs. 12.6 percent).[8]

Excluding reproductive health services, data from 2002 show that males and females ages 10–24 generally use health care services for the same conditions. Major disparities include: more males reporting visits for trauma-related disorders (3 million vs. 2.3 million) and more females reporting visits for bronchitis/upper respiratory infections (3.9 million vs. 2.9 million). Similarly, for trauma-related disorders, more males than females report emergency room visits (2.2 million vs. 1.4 million); hospital stays (155,000 vs. 42,000); and use of prescribed medicines (1.7 million vs. 1.3. million).[9]

What are the Priority Health Problems for Boys and Young Men of Color for Health Services to Address? Analysis of the Implications of the Facts

Profile reminds us that young minority males are in the period of life for taking risks and forming habits that go far in determining the future of personal health and productivity, the quality and length of life, and the cause of death, whether premature or coming in the fullness of time. While fighting for personal independence, do they actually have and exercise more power over their own lives and deaths than they are conscious of? The following are among the lessons *Profile* suggests:

1. Health risks and conditions of priority for adolescent boys and young men are not unknown—they have been identified.
2. The nature of the risks and conditions identified means that, in order to protect the health of young males, it will be necessary to offer a continuum of services and strategies from medical care to public health, youth development, and community development.
3. A lifespan approach should be taken to the health of males. *Profile* makes the following observation: "The prevalence of many problems—including homicide, unintentional injury and substance use—are [sic] highest among young men in late adolescence and early adulthood. Initiatives to improve men's health should include components tailored to the needs of adolescent and young adult males."[10]
4. The context for *Profile*'s publication gives advocates for young minority males opportunities to seize. First is the opportunity to capitalize on the energy and attention others are putting into health issues both for men and for male and female adolescents and young adults. Second is the opportunity to say, within the framework of these efforts, "Give boys and young men of color the priority their plight warrants. Do not forget them." Several developments contribute to this context. *Profile* notes, for example, that "[f]ederal policymakers and other stakeholders are increasingly aware of the importance of young men's health and well-being. For example, many states have established offices of men's health or issued reports on men's health. Congress is considering establishing an Office of Men's Health."[11]

Profile picks up on the emerging interest in male health and applies it to the body of work on the 10-24 age group under *Healthy People 2010*. A key step in this work was the selection of 21 (out of 467) objectives from *Healthy People 2010* that a panel of experts thought most critical for adolescents and young adults. As *Profile* reflects, the selected objectives concern *mortality through unintentional injury and violence, substance abuse, mental health, reproductive health, and preventing chronic disease in adulthood.* Choosing the objectives led to the National Initiative to Improve Adolescent Health by the Year 2010. A milestone for the initiative is publication of *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities* (hereinafter *Guide*).[12]

Aspects of *Guide* are pertinent to the idea of a continuum of services and strategies from the fields of medical care, public health, youth development, and community development. The authorship of *Guide* itself reflects the need for multiple perspectives and resources. It was co-produced by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the National Adolescent Health Information Center at the University of California at San Francisco. The *Guide* tries to up-end some old ways of thinking:

> The National Initiative is an ambitious endeavor that challenges the nation to create new ideas, methods, and strategies to move forward in promoting adolescent health. To make improvements in the health of our nation's young people, relevant agencies will need to nurture and expand their partnerships, especially at the state and local levels. In addition, we need to be creative in working with the various societal institutions that influence the behaviors and health of youth. Many individuals, agencies, and organizations, along with youth and their families, need to be a part of a long-term dialogue to incorporate the best science, effective strategies, and resources into the National Initiative to Improve Adolescent Health by the Year 2010.[13]

> Using the National Initiative's framework to address adolescent health problems requires developing new approaches, working with a variety of partners, and conceptualizing adolescent health from a new perspective. This document departs from traditional approaches to adolescent health in at least three ways: it (1) de-emphasizes a categorical approach to addressing specific health problems; (2) emphasizes a multilevel approach rather than concentrating on changing the knowledge and behaviors of individual adolescents; and (3) simultaneously takes a youth development approach, one that embraces adolescents and young adults proactively as part of efforts to promote their health and safety rather than as "problems to be fixed."
>
> Relying on a categorical approach alone ignores the fact that there are many common antecedents to seemingly disparate health problems. Research has clearly shown that risk behaviors tend to cluster and that engaging in one risk behavior often contributes to other negative health outcomes… [S]ome studies have demonstrated that programs and interventions that integrate youth development approaches are effective in protecting youth against engaging in health risk behaviors. Even so, prevention efforts should not focus on youth development to the exclusion of initiatives aimed at reducing health problems and risk behaviors… Regarding our multilevel approach, we believe there is great danger in the common practice of emphasizing the personal attributes and behaviors of adolescents while neglecting the effects of the environments in which they live. This document stresses addressing adolescent health problems at the levels of individual/family, school/peers, community, and policy/society.[14]

Features of a Continuum of Services and Strategies for Boys and Young Men of Color

What are the key features of a health protection continuum of services and strategies from medical care to public health, youth development, and community development for young minority males? Groundwork has been laid in two fields. One field, the health of adolescents and young adults, has well-developed ideas. The other, men's health, is an emerging field; its further development is now being stimulated by the Kellogg Foundation's Community Voices Initiative managed at the National Center for Primary Care of the Morehouse School of Medicine. What contribution should advocates for boys and young men of color make to defining the features of the continuum? What features in the continuum are especially important for lowering barriers on the life pathways of young minority males? The following discussion answers these questions in part. Later parts of the paper delve into mental health and substance abuse, which are top priority health issues for male youth of color; into school-based health care, a vital point of access; and into the requirements for good health services for special populations of young minority males: those in, or re-entering the community from, the criminal justice, juvenile justice, or foster care systems.

Guide, *Profile*, and the National Initiative to Improve Adolescent Health by the Year 2010 show that thinking in the field of adolescent health in the 21st century has reached the stage of putting a blueprint for action in place. Another illustration of this thinking is *Investing in Adolescent Health: A Social Imperative for California's Future* (hereinafter called *Investing*) from the California Adolescent Health Collaborative. Its approach to investment is comprehensive. The underlying idea is that youth health comes not just from medical care but from many influences and opportunities in many settings. This can be seen in the scope of its eight core recommendations: (1) Build strong public support for investment in youth; (2) Involve youth in the policy process; (3) Ensure access to comprehensive, youth-friendly health services; (4) Coordinate service delivery systems for adolescents; (5) Build stable families that can support teens; (6) Create communities that offer youth positive life options; (7) Design schools to promote health and development; and (8) Use data to support responsive programs and policy.[15]

What will ensure that boys and young men of color are not marginalized, that they benefit fully from a continuum of health services that belongs to them and serves them as much as it belongs to and serves others? The following are two core principles advocates could stress to inform policy and practice for health services for young minority males:

1. *A continuum of services must have sufficient resources.* A systemic investment strategy should ensure that health protection for boys and young men of color is both adequate and equitable.

    - *Equity* speaks to equality in access to care. The nation's public and private resources for health protection should be distributed equitably so that, at a minimum, all boys and young men of color are eligible for—and are provided—health coverage and services.

    - *Adequacy* speaks to the characteristics of the services provided boys and young men of color and the delivery system through which they are provided. While equity addresses equality of access, adequacy addresses the question, "access to what?" The level of investment in health protection for boys and young men of color must be adequate to address their unique needs and the disproportionate burden of health risks and health problems they bear.

2. *Services in the continuum must be designed, organized, and delivered in ways that build trust and build community.*

This paper explores the implications and implementation of these two principles, which should guide development of the continuum of services. The paper then concludes discussion of features of the continuum by examining certain diseases that must receive top priority in the continuum because of their devastating and spreading effects in communities of color. These are sexually transmitted infections (STIs), including HIV/AIDS.

Principle One: A *systemic investment strategy* should ensure that health protection for boys and young men of color is both *adequate and equitable*. Investment in the health of young minority males is investment in their futures and the nation's future. Advocates, policymakers, and practitioners should articulate that investments in the health of these young people generate personal, social, and economic benefits that exceed costs and, further, save the personal, social, and economic costs of the negative outcomes of poor health and health practices and of preventable death and disability.

The National Initiative to Improve Adolescent Health by the Year 2010, *Guide*, and California's *Investing* show that the need for a comprehensive, multilevel set of action strategies is now being articulated in the field. To support such a set of strategies, a more complete range of investments than exists today will be necessary. The level of investment necessary to fully meet need will have to be calculated. A zero-sum methodology (which takes money from one area in order to invest in another) should not be used.

Advocates for young minority males should help policymakers who are making investment decisions see the whole picture of a continuum of services. Seeing the whole picture can be difficult. Governmental budgets don't come with line items for "health of adolescents and young adults," much less with "health of minority male adolescents and young adults." Pertinent funding lines and programs are typically scattered across the bureaucracy. Budget narratives can pull together the threads for any given priority. But governors' budgets can present only a limited number of priorities, and policymakers won't demand and use a consolidated discussion of budget lines pertinent to the health protection of young minority males unless they are committed to the subject and have the "strong public support for investment" that *Investing* refers to. Even committed policymakers who have constituent support may not know all the questions to ask to stimulate formulation of the big picture in budget documents and legislative hearings.

The African American Drug Policy Coalition, whose goals include reallocating resources, frames issues in a way consistent with looking across agency and program budgets and even *changing the budget architecture*. The coalition's founder, former National Bar Association president Clyde E. Bailey, Sr., put it this way: "What we hope to do is to shift public resources into education, prevention, treatment and research programs that have proven more effective in reducing drug abuse rather than through the use of expensive criminal sanctions. We are trying to focus on the health issue of these people rather than criminalizing that behavior."[17]

Advocates can lay the groundwork for presenting the whole picture of services and strategies. But this can take time and persistence. A local-level model for organizing to get the cross-agency, cross-program look at issues and investments that a comprehensive investment strategy calls for can be found in San Francisco (perhaps not surprisingly, since the University of California at San Francisco is the home of the National Adolescent Health Information Center, which wrote *Profile*). In January 2003 the *new* Office of Adolescent Health in the San Francisco public health department put out the *Adolescent Health Plan 2003-2005*.[18] It was modeled on *Investing* and intended to "be followed by a citywide plan to be issued in 2005."[19] The health department's development of the plan had many participants: four other departments of municipal government, the citywide school district, 20 community organizations, and the California Adolescent Health Collaborative (the source of *Investing*). The health department itself operates teen health centers. Other centers, located in schools and called Wellness Centers, are the result of collaboration between two departments and the school district (see pre-

The Wellness Center Initiative[16]

The Wellness Center Initiative is a collaborative effort of San Francisco's Department of Public Health and Department of Children, Youth and Families and the San Francisco Unified School District to support adolescent health and wellness. The wellness centers emerged from a youth-initiated process spearheaded by Youth Making a Change and are located in seven high schools. The centers' goals are to increase:

- Youths' awareness of and access to health services
- Health-related information at all grade levels
- Outreach and linkages to community partners
- Youths' healthy behavior and capacity to develop personal and social skills
- Access to substance abuse prevention services
- Access to mental health services
- Youths' attachment to school
- Youths' academic performance

ceding text box). One of the community organizations, the Adolescent Health Working Group, has a mission statement that articulates well the concept of a multi-sectorial service continuum:

> To influence, create and change procedures, policies and laws to ensure delivery of an age appropriate and culturally-competent continuum of integrated health services that emphasizes youth development, health promotion, prevention, harm reduction, psychosocial guidance, and family education and support.
>
> The important task of addressing and improving youth health and well-being rests with families, community members and institutions, professionals that come into contact with or work on behalf of youth and health care providers, services/programs, and systems.[20]

Another illustration of why time, effort, coordinating, and organizing (not to mention overcoming turf disputes and ingrained mistrust and competition for resources) will likely be needed to "get the big picture" can be found by examining the respective roles of offices of adolescent health, minority health, and men's health. A number of governments at different levels have created—or considered creating—one or more of these three types of offices. Each type of office could contribute to developing a systemic investment strategy for health protection of young minority males. But no one type alone has a jurisdiction that is coterminous with the interests of boys and young men of color. To ensure that these types of governmental offices—and, indeed, all governmental offices with "pieces of the action" for young minority males—cooperate and coordinate their efforts, state legislatures should set expectations and exercise oversight.

The legislature must use its oversight function to ensure coordination and reporting of all public investments in improving the health of boys and young men of color.

The field of investment in health protection might borrow principles from the field of school finance. There, progress in thinking and litigation have established companion principles: equity and adequacy.[21] *Equity* came first. The idea is that variations in levels of per capita spending on public schools that are based on variations in property values from district to district are inequitable. The child in a richer locale does not "deserve" a more-resourced education than the child in a poorer locale. *Adequacy* then emerged. The issue is not just whether a school district has equivalent funding but whether it has enough funding to achieve a desired level of student performance. *Where need is higher, spending should be too.* In a 1999 report, the National Research Council of the National Academy of Sciences enunciated a prime goal for school finance: to break the nexus between student achievement and student background characteristics, which include family and community poverty.[22] In the domain of health disparities for young minority males, an analogous idea could be to break the nexus between health risk and health status, on the one hand, and race/ethnicity, gender, and socioeconomic status on the other. The reference point for setting the level of investment is the amount of resources necessary to break the nexus. That level should reflect the disproportional risks to health arising from race/ethnicity, gender, and socioeconomic status.

A "budget" for health protection of young minority males should, then, be driven by an estimate of *how much needs to be spent in total so that all services and strategies have sufficient funding and no service or strategy is sacrificed for another.* Put colloquially, budgets should not "rob Peter to pay Paul." Budgets should not trade off between investments in primary care safety-net providers and investments in health care coverage. *Coverage for all to purchase care is a matter of equity. Investment in the delivery system to enable it to serve people with higher needs is a matter of adequacy.* One kind of investment cannot be substituted for the other.

The federal budget provides an example of trade-offs between these kinds of investments. President Bush's five-year, $780 million Health Centers Initiative proposed in FY2002 has infused resources into expanding existing community health centers and starting new ones. But there was not a companion initiative to pump resources into Medicaid. Medicaid, instead, has been increasingly targeted for budget cuts.[‡] While community health centers have received new resources for expansion, their long-term sustainability has not been guaranteed. They have been operating in a volatile policy environment, and developments in the last decade have jeopardized their future. They have seen Congress first decide to phase out over five years the cost-based reimbursement they receive in recognition of their extra costs for serving the uninsured and then, later, pass a moratorium on the phase-out. They have dealt with a change in the market in which they operate brought on by Medicaid's push to enroll recipients in managed care. They are experiencing the effects of marketplace and public policy decisions that result in a rising number of uninsured as fewer people have access to employer-based private coverage and budget-tightening in Medicaid and other programs limits eligibility for public coverage. The more uninsured patients they serve, the more community health centers depend on congressional funding decisions, yet those

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[‡] While there have also been policy changes to bring Medicaid coverage to some groups of people who are outside the traditional eligibility requirements, these changes require budget neutrality; hence, they do not expand coverage so much as shift coverage. One ripple effect of not directing more resources toward Medicaid is to place more stress on the Indian Health Service (IHS). While IHS serves most of its clients through a system of IHS facilities, health programs operated by tribes, and private contractual providers, it will pay for services received by Native Americans it cannot serve. It is, however, a payer of last resort that pays only if Medicaid will not.

decisions are being made in a climate of intense demands on the federal budget and increased volatility in the appropriations process.

This phenomenon can be seen, for example, in appropriations decisions Congress made in 2003. At the same time that it made an annual appropriation of new funds for the president's five-year expansion initiative, Congress asked the federal agency administering the initiative to divert part of the new money to help existing centers with the costs of serving the uninsured in their existing patient caseloads. As an officer of a large state association of health centers said at the time, "The growth in the uninsured has put a tremendous squeeze on existing centers who are maintaining a high level of care while serving more people without health insurance."[23]

Such budgetary competitions—between funding coverage and funding safety-net providers; between adding community health centers and shoring up existing ones—primarily concern treatment. In comparison to public spending on treatment, public spending on health promotion and disease prevention has always been very marginal. It is, therefore, crucial for health education to become a federal and state resource priority within the health investment strategy this paper outlines for boys and young men of color. Treatment, of course, must not receive short shrift, but policymakers must recognize that the health education needs of these youth are far, far greater (although much less costly to meet) than their needs for treatment. Health education should be given muscle and turned into a powerful counter-force against the health risks attendant upon growing up male and of color in America. Practical policies to give health education the priority it requires are proposed in *Investing* by the California Adolescent Health Collaborative:

> Improve school health education by making health education a high school graduation requirement, promoting health education in every grade based on sequential standards and curricula, increasing teacher training in health, improving dissemination of research-based health curricula, and improving health education programs for teens with learning or developmental disabilities.[24]

The health education curriculum for young minority males cannot be just any health education curriculum. A curriculum that is right for them must impart the knowledge and skills both to take responsibility for their own health and to challenge the health care system (due to the legacy of the Tuskegee syphilis experiment and other experiences discussed below).

San Francisco is home to another development that is relevant here. This is the creation of the H.E.A.L.T.H. Curriculum by the Adolescent Health Working Group, which explains the curriculum as follows:

> The Health Curriculum is a workshop that was created because previous outreach efforts with adolescents clearly pointed to a deficit in youth's awareness of key health concepts and youth's inability to obtain services in the San Francisco health delivery system. Our experiences confirmed that youth lack basic knowledge of the importance of being in control of one's health at an early age, and exercising principles of self-advocacy and prevention in order to be active and savvy consumers of the health care system by focusing on the following components of the presentation [sic] H-having knowledge, E-enrollment and A-access, L-living healthy, T-total, H-health. Through the use of this acronym, the workshop provides the following:
>
> - Information on health topics
> - Examples of how to ask questions of a health provider
> - Prevention tips
> - [B]asic steps teens can take to impact the quality of health care they receive
> - [Guidance on how to] [i]dentify various methods of health insurance coverage.[25]

The curriculum is a good model or starting point for improving health education for young minority males.

Principle Two: Services in the continuum must be designed, organized, and delivered in ways that build trust and build community.

Fear is a high barrier to access. It affects willingness to seek care, willingness to comply with treatment regimens, and receptivity to strategies for primary and secondary prevention. Minority males cannot be effectively reached and engaged with the health system unless their fear and mistrust, and the grounds for them, are affirmatively recognized, respected, and addressed. The larger context is the negative experience of minorities. For example, survey research has found "that 43 percent of African Americans and 28 percent of Latinos compared with 5 percent of white people, felt that a health care provider treated them badly because of their race or ethnic background."[26] Native Americans' lasting fear is recounted in *Offering TA to Native Families: Clues from a Focus Group*. The particular context is an effort by the Federation of Families for Children's Mental Health to reach out to Native American families to provide them technical assistance to be advocates for themselves. (The Federation is an association of family-run associations located in the states.) The publication probes into why establishing cross-cultural trust even in this context is difficult. It recounts stories from parents and grandparents about frightening, horrific abuses of Native people by whites including physical violence against children and adults, taking of a family home, removal of children from their tribal community, and suppression of tribal languages and spiritual practices. One mother said "that the grandmothers in her community still keep a hiding place in the woods prepared for the children. They still fear that the white people will come and take them away."[27]

Similarly, a legacy of the Tuskegee syphilis experiment[**] is fear. In response to the experiment, some African American men fear that going to health professionals may turn them into guinea pigs. Another kind of fear is of being told they are worse off than they actually are. Some fear being committed to mental institutions—a credible fear in light of black men's higher rates of involuntary psychiatric hospitalization and higher rates of inpatient, rather than outpatient, treatment for mental health problems, as discussed in the mental health section below. That section also reports on research findings that low-income adolescents who are not psychotic are being prescribed, without a solid clinical research basis for the practice, antipsychotic drugs that have adverse side effects such as weight gain and diabetes. This finding is relevant to the fear some African American men have of being placed on medications that will actually worsen their medical conditions. What lies behind this fear is suspicion, not about a white physician's competence, but about the intent of the physician, who may be suspected of feeling malevolent and aiming to use medical knowledge to harm the patient. In short, the Tuskegee experiment taught African American men in the most horrible terms that the Hippocratic injunction to do no harm can be suspended if the patient is descended from slaves. In our nation a few swipes with a rag called cultural competence will not wipe this slate clean. A profound and pervasive cultural transformation is needed.

Communities of color and boys and young men of color should wait no longer for this transformation to occur. They themselves can be resources for creating the changes they need. The capacity of young minority males to take responsibility for their health and health care can be built. (An outstanding illustration of this is the PERCY Project, discussed under the special topic below. PERCY stands for Peer Education and Reproductive Counseling for Young Men.) Equally important, promotion, prevention, detection, and treatment services can be organized and delivered so that youth experience them as "trustworthy," and community organizations and youth can be drivers in making that happen. Community organizations, including organizations of minority men, and community initiatives can start health education efforts for boys and young men of color earlier and include in them the "mentoring of schoolchildren by black professionals to prevent drug use"[28] that the National African American Drug Policy Coalition is calling for.

An exemplar of citizen action for men's health is the Baltimore Community Voices project, part of the national Community Voices: HealthCare for the Underserved Initiative funded by the W.K. Kellogg Foundation. The Vision for Health Consortium, a community organization in the Sandtown-Winchester neighborhood of 10,500 residents in west Baltimore, was the lead partner when the project began in 1998. With Vision for Health as the driving force, another partner, the city health department, opened the nation's first full-time, full-service primary health and dental care clinic for uninsured men. Men ages 19-64, many of them recently released from prison, receive free care, including counseling for substance abuse, and can be linked to jobs. This innovation sparked men's health work in other Community Voices sites and, then, further support for men's health projects by the Kellogg Foundation working through Morehouse School of Medicine. Some of the new work on men's health has been to establish men's health programming within community-based clinics. Because of its origins, the Baltimore Men's Health Clinic stands for two policy targets. One is state and local funding of men's health services. The other is support for community-based partnerships for health that bring minority community advocacy and action organizations together with the agencies and institutions that have the financial resources and organizational infrastructure and networks[††] to make visions into realities.

Another resource for building trust and problem-solving capacity within communities is the community health center, the safety-net provider discussed earlier. These centers combine community-connectedness with resources and infrastructure to meet community needs. Centers have special capacities to serve linguistically, racially, and ethnically diverse populations of poor and low-income people in their neighborhoods and in ways that are responsive to their circumstances and the higher risks to good health in their lives. They advocate on both the policy level and the individual level. Thus, community health centers stand as guardians and advocates to protect access and health among the people in the communities they serve.

Communities can foster the role of young people as resources for their own health. The Muskegon Community Health

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[**] In the Tuskegee syphilis experiment (1932 to 1972) 399 African American men from an impoverished area who had, unknown to themselves, advanced syphilis were told they were being treated for "bad blood." Their actual disease was left untreated so that their ravaged bodies could be studied in post-mortem autopsies. The experiment was sponsored by the U.S. Public Health Service.

[††] Agencies' connections to resources matter. The Baltimore Men's Health Clinic was started up with reallocated TANF (Temporary Assistance to Needy Families) dollars, creating the interesting result that money appropriated primarily for the benefit of mothers and children was shifted to the benefit of men who are primarily either childless or non-custodial parents.

Project in Michigan promotes personal responsibility for health in several ways. For example, working adults who wish to participate in the Access Health coverage plan, which it created for small businesses (see Appendix), must enter into a personal health agreement. For adolescents, the Community Health Project promotes personal responsibility through a group mentoring program, Men and Women of Character, which serves boys and girls separately. "[A]t-risk teens, primarily African Americans … learn morals and positive decision-making skills, modeled by the adult mentors. To broaden the youth's experiences, the program includes activities and trips to museums, camping and fishing sites."[29]

The Boston health department capitalizes on young minority men as resources for better community health through Boston HealthCREW. HealthCREW provides training and hands-on experience to young men of color ages 18-25 who are high school graduates so they can work as health educators with other young men in Boston.[30] Community health workers are increasingly recognized as invaluable resources to educate, advocate for, and support diverse community members and connect them to institutional health services and health care coverage enrollment opportunities. The earnings of these workers also contribute to their communities' economies. Further, in some settings, becoming a community health worker can put an individual on a career ladder. Historically, community health workers have often been women, partly because of efforts to improve outreach to marginalized pregnant women; today, more male community health workers are being recruited.

The trust of teens can be built by putting trust in them, specifically by engaging them in the design of service venues and service delivery. Advocates for Youth, a national organization, "is committed to shifting society's paradigm regarding youth, including youth of color, away from one that views them as 'problems to be solved,' and towards one that values them and that eagerly seeks their full participation in designing and running programs for young people. Advocates for Youth calls this paradigm shift the 3Rs—Rights. Respect. Responsibility.®"[31]

Accurate data and other information are very important to designing services that are genuinely responsive to the needs of young minority males. Obviously, data compiled by agencies should be made available to young minority males and other youth who are participating in the youth engagement process. However, the process should go beyond using extant data to include gathering new data, specifically through community-based participatory research. This will optimize the opportunity the process affords for youth development and community development. In this research method, community members participate in framing the research questions, designing and conducting the research, and using the results. Community-based participatory research is increasingly recognized as a powerful tool for catalyzing community action, enabling research dollars to produce results that are more relevant to communities, and bridging the chasm between communities and the health and educational institutions that conduct research.

Designing services that teens can trust is a top priority advocated by the California Adolescent Health Collaborative, which recommends the following:

> Make health care easy and comfortable for all teens to access by publicizing health care options available to youth through outreach and education; promoting point-of-service eligibility and on-site self enrollment in public programs; eliminating co-payments and premiums for all youth; establishing minor consent for non-emergency, primary medical care; creating health and social services that are welcoming, comfortable, easy for teens to use, and protect the rights of minors; and identifying health plan providers who specialize in serving teens.[32]

Building community around health among the young demands the greatest sensitivity to racial and ethnic diversity, because the nation's greatest diversity is among the young. Calling for sensitivity to differences in history and what it calls "community memory," Advocates for Youth points to differences in perception about the Tuskegee experiment: "[M]any African Americans—remembering the infamous Tuskegee syphilis study—are suspicious of government agencies, fearing that genocidal intentions underlay HIV/STI and pregnancy prevention efforts. As a result, they may be unwilling to use condoms and/or to be tested or treated for HIV/AIDS. At the same time, some black Americans, such as those with a Caribbean background, may not share this particular history of governmental abuse. Thus, programs must be tailored to address different cultures."[33] Nor can individuals simply be denominated "Native American," according to Advocates for Youth: "Native Americans/American Indians possess individual languages, differing customs, and unique cultures and histories. Attitudes toward health and illness, sexuality, and wholeness differ widely. HIV/STI and teen pregnancy prevention programs must be individually tailored to each culture."[34]

Further, the National Association of Social Workers advises that considering only racial, ethnic, and cultural diversity is too "limited." What also count are "gender, socioeconomic, religion or spiritual belief, age, disability, and sexual orientation, [which] … all are important and influence health outcomes."[35] Advocates for Youth emphasizes that bicultural or multicultural youth may not want to be treated as if they are monocultural.[36]

Besides participating in the design of service delivery, young minority males have vital roles to play in building the healthy communities that will, in turn, promote their own health and well-being. Indeed, the very process of participating in creating healthy communities creates health in the participants. A new kind of thinking has entered into community development and social work, which are important parts of the continuum of services. As Ewalt, Freeman, and Poole report for their social work colleagues in *Community Building: Renewal, Well-Being, and Shared Responsibility,* community members, including the young, are now understood as wellsprings and leaders of community development: "The new era of community renewal has dramatically changed the role of social workers in community practice. Social workers once assumed the role of change agent, mobilizing community members through locality development, planning, and social action. Today, greater emphasis is placed on encouraging community members, including youths, to participate and assume leadership roles in all phases of community capacity development. This realignment of roles is sometimes characterized as a shift from 'community organizing' directed primarily by professionals to 'community building' directed primarily by community members."[37]

Special Topic: HIV/AIDS and Other STIs (Sexually Transmitted Infections)

This topic deserves special attention due to the deep and devastating impact of HIV/AIDS on some African American communities. Nearly one-third of new HIV/AIDS cases are among black men ages 20-24,[38] while one-half of new cases are among black men of all ages.[39] It is also relevant that the estimated number of inmates released from prisons and jails in 1996 who were HIV-positive was between 98,500 and 145,000, while the number estimated to have AIDS was 38,500.[40] Behind these statistics lie stories of tragic deterioration in communities, deterioration not only of health but of social and economic conditions as well, even leading to a rise of anomie. A paper for the Kellogg Foundation on the invisible gender gap minority men experience in higher education comments on such a story by reporter Lynette Clemetson:

> In August 2004 the *New York Times* told the story of Louise, a HIV+ young woman from a small town in North Carolina, because it "illuminates a complex domestic issue: the link between high rates of imprisonment among African-Americans and high rates of HIV and AIDS." According to the *Times*, "[r]esearchers say high incarceration rates increase risk behaviors associated with HIV by skewing the ratio of women to men, worsening economic conditions and increasing the social capital of men who are not imprisoned." The incarceration rates in her town were such that "[t]he only jobs…[Louise] said, were generally at fast-food places, farms or factories. Entertainment consisted of hanging out on the street corner or at the strip mall. And as for men, she said, with an air of resignation, 'They've either been in prison, they're married or they're gay.' It never seemed unusual, said Louise, that nearly all the men she had been involved with—including the one who passed the virus on to her—had been in prison." Her personal tragedy matches with the finding from a county-by-county epidemiological study of "a 'robust correlation' between incarceration rates and the rates of HIV and other sexually transmitted diseases." The high rates of incarceration of black men are doing more than spreading deadly infection among poor black women. "You're not even looking at six degrees of separation in most black social networks between a disenfranchised former inmate and someone who is in college or highly respected in the community," one public health official said. The *Times* also reports that some groups of women in the community have adopted the practice of consciously sharing a man because so few are available. Further, pressure is being placed on married men, some of whom are succumbing, to commit adultery. That the *Times* characterizes this situation as an increase in the social capital of men who are not imprisoned is a sadly ironic twist on the usual sense in which the term is used.[41]

This spread of HIV/AIDS can be viewed as the consequence of social injustice, racism, and shameful dereliction of duty by public officials. In these circumstances, advocates who wish to promote both male responsibility and community-wide responsibility for solving the problem may find it a challenge to argue that young men of color and their communities can take charge, that it is possible and not too late. Guides to best practices and model programs with a focus on males of color do exist. A sample of information is summarized below. But a good program here and a good program there do not represent either a comprehensive strategy of investment in better health for young minority males or a community anti-AIDS movement that spreads as vigorously as AIDS itself spreads. In such a movement, communities of color would demand prison reform from officials as well as responsibility from males of color. Advocates of youth- and community-centered solutions have much more work to do to inspire such a movement. The PERCY Project, referenced in the summary, deserves attention because it *is perhaps the most striking illustration of a cultural transformation strategy that takes the form of transforming the oppressed's response—from killing themselves to saving themselves.*

Programs Addressing HIV/AIDS and other STIs

1. Broad guidance comes from Advocates for Youth, which stresses incorporation of culturally relevant approaches into HIV prevention and other health education programs:

> Incorporate traditional elements of the culture(s) of youth served. Building upon the cultural beliefs and practices of client youth will reinforce the attitudes and skills the program seeks to strengthen. For example, an HIV prevention program for African American youth might build rites of passage into its efforts.[42]

2. The underlying premise of the Peer Education and Reproductive Counseling for Young Men (PERCY) Project of the National Organization of Concerned Black Men, as expressed by the professionals who manage the program is provocative and insightful:

> Upholding traditional notions of masculinity may be said to be killing men. The attitudes and behaviors that young men of color adopt to cope with their culture's definition of masculinity may lead to the serious health disparities they experience. To eliminate these disparities, innovative, culturally sensitive, gender-specific interventions must challenge young men's notions of masculinity.[43]

Addressing sexual health among young black males, the PERCY Project stands out because it is founded on a penetrating theory about why minority male health is so comparatively poor. A young black male's "cool pose" may be a strategy for coping with the barriers—educational, employment, and other—that block him from fulfilling the masculine role of provider/protector. This pose aims to hide self-doubt and substitutes uncaring aloofness and toughness for insecurity. Toughness may mean not going to doctors, not showing warmth in intimate relationships, and not resolving conflicts peaceably. "Tough behaviors, encouraged by the cool pose, certainly contribute toward young men's rates of violence, suicide, substance abuse, HIV infection, and unplanned fatherhood," say the PERCY Project director and colleagues.[44] They point to the strain theory—or gender role strain paradigm—which says "that inconsistencies between societal expectations and available opportunities for success cause personal frustration and alienation, driving people to risky behavior."[45] Interventions try to counter these feelings by offering skills and strategies. The PERCY intervention counters the influence of the "cool pose."

3. Charlas Entre Nosotros is a peer-to-peer program for HIV/AIDS/STI prevention that the National Council of La Raza developed and piloted through four community-based organizations, including a community clinic in California. Participating youth were ages 13-19. Learning to resist peer and societal pressures and strengthening cultural values and concept of self were main aims. Each youth participated in four two-hour sessions led by youth facilitators.[46]

4. In July 2000, the Office of Population Affairs/Office of Family Planning in the U.S. Department of Health and Human Services published *Male Involvement Projects: Prevention Services*,[47] reporting on projects funded in the prior three years aimed at integrating family planning and reproductive health services and education into health, education, and social services that young males were already receiving. A number of funded projects include training, internships, and jobs for young minority males. Clinic services for males in primary care and reproductive health, health education for STI prevention and use of condoms, curricula used in schools and youth-serving organizations, mentoring, and peer outreach and education are among the activities in funded projects. Those served include men in substance abuse treatment and recovery and prison pre-release programs and boys in public housing projects and community youth programs. The PERCY Project received funding, and projects of other minority male organizations were funded. Racial and ethnic diversity among the male participants clearly was a goal of the funding. In addition, some projects in the group served special populations, that is, migrants, the homeless, and reservation school children.

5. Programming of a community health center in Oakland, California, is described this way by M. C. Leung of the Asian and Pacific Islander Health Forum: "In Oakland, California, Asian Health Services incorporates hip-hop into a three-session workshop. First, youth identify the hip-hop skill they would like to learn. In the second and third sessions, an HIV expert from the hip-hop community teaches the chosen skill along with important, culturally appropriate HIV/AIDS information."[48]

Screening for Chlamydia

Profile reported that chlamydia rates are much lower for males, but among them blacks are disproportionately affected. In 2004 the chlamydia rate for black males ages 15-19 was three to 17 times higher than the rates for males in the same age group of other races or ethnicities.[49] Compared to whites, in 2001 the black rate was 12 times higher—1,550 per 100,000 among black males compared to 128 per 100,000 among white males.[50]

In an article in the October 2005 issue of the *American Journal of Public Health*[51] a group of medical and research professionals from several California health care institutions presents the following facts and issues: More than 3 million new cases of chlamydia occur annually. Adolescents are disproportionately affected. Many more girls and young women than boys are infected, and the potential consequences for girls are more dire, including, for example, ectopic pregnancy and total infertility. Screening is crucial because chlamydia is asymptomatic. Virtually all the attention has been given to increasing the screening of girls and young women. Currently, the only quality standards in the field that call for screening males are from the American Medical Association. However, the infection can cause medical conditions in males, who also can infect females. The case has been made for screening incarcerated minority male youth, who have a high prevalence of chlamydia. Three recent studies of the general healthy young male population found rates of 3.7, 3.8, and 5.3 percent respectively. The highest rate was found in military recruits. The 3.8 percent rate was found in ethnically and racially diverse adolescent male members of an HMO in the Bay area. While not alarmingly high, these rates of a sexually transmitted infectious disease that spreads silently and can cause lasting harm to some do suggest that the advisability and cost-effectiveness of expanding screening for boys and young men ought to be considered.

Recommendations for Action

Policymakers should provide direction and funding at the state and local levels for the establishment of a continuum of health protection encompassing medical care, public health, youth development, and community development that is designed for and accessible to all young underrepresented minority males as well as all adolescents and young adults. (State and local investments should be backed by federal resources.)

- A systemic investment strategy should support the continuum of services. The investment strategy should ensure the adequacy and equity of investments in health protection for boys and young men of color. Budget architecture should be revised to enable the total investment in health protection of young minority males to be seen and understood.
    - ➢ The principle of adequacy requires that the design, scope, and nature of the services are adequate to meet need. Levels of investment to ensure adequacy must be based on a clear understanding and estimate of the total spending needed, regardless of where components of the spending are housed in public budgets, for eradication of the disproportionate impact of health risks and health problems on the life pathways of boys and young men of color.
    - ➢ The principle of equity requires universal access to the services in the continuum. The preferred method for achieving universal access is universal health care coverage (as discussed below in the section on enrollment and outreach).
    - ➢ The principle of adequacy requires strengthening the delivery system by supporting and sustaining providers that serve adolescents and young adults, especially boys and young men of color. These include local public health agencies, community health centers, and other safety-net providers of primary health, oral health, and behavioral health care.
    - ➢ The comprehensive investment strategy should include, *inter alia*, local-level, jurisdiction-wide planning and implementation that are supported in state and local budgets. The public and private sectors should collaborate in planning and implementation.
- Legislatures should set the direction for cross-agency, cross-program, and state-local cooperation and coordination to support the continuum and ensure that the perspectives of male health, minority health, and adolescent and young adult health can be brought into focus together. Legislatures should identify the organizational units responsible for coordinating, leading, and guiding the work. Each legislature should exercise oversight of coordination and implementation of the continuum of services; the use of resources invested in the continuum, including how dollars are being invested in underserved communities; and the reporting of the health status of boys and young men of color.
- The design of the continuum of health protection services and the delivery of services within it should follow best practices for adolescent and young adult health in line with the National Initiative to Improve Adolescent Health by the Year 2010. They should also incorporate sensitive attention to issues specific to young minority males. The specific characteristics or components of the continuum to support boys and young men of color should include the following:
    - ➢ Youth engagement strategies must fully engage young minority males. A best practice for the continuum is youth engagement to ensure the participation of youth in planning service environments. Youth should also participate in service delivery through peer-to-peer outreach and support. Implementation of these strategies must ensure that young minority males are involved as central

players, not as tokens. Agencies should not take credit for successful youth engagement unless they can document the extent of young minority males' participation.

➢ Supports, such as mentoring and tailored health education curricula, that are especially important for young minority males in developing good health practices early, taking personal responsibility for health, and knowing how to question health professionals, must be embedded in the continuum. Health education should permeate the continuum and be delivered in a variety of venues and by a variety of public and nonprofit organizations.

o Development and promotion of mentoring programs to help school-age boys avoid drug use should be given special attention.

o The H.E.A.L.T.H. Curriculum of the Adolescent Health Working Group in San Francisco should be used as a model.

o Best practices for culturally specific programs in reproductive health such as those identified by Advocates for Youth should be followed (see text box below). The model demonstrated by the Peer Education and Reproductive Counseling for Young Men (PERCY) Project of the National Organization of Concerned Black Men should be adapted to the range of culturally specific needs of young minority males and widely used around the nation.

From
"Masculinity—Contribution to Health Disparities for Young Men of Color"[52]

Young men of color need culturally specific programs that:

- Provide gender-specific sexual and reproductive information within a cultural context;
- Promote a positive self-concept, including self-esteem, self-efficacy, self-respect, and life skills;
- Build their skills in communication, negotiation, and refusal;
- Provide confidential access to clinical care and health services; and
- Build youth-adult partnerships by involving young men in programs' planning, implementation and evaluation.

o Health education in K-12 should begin early and be systematically upgraded, including by establishment of a requirement for graduation. Training to prepare instructors to deliver age-appropriate, culturally appropriate health education should incorporate special attention to the racial, ethnic, and cultural diversity among young minority males and to their needs, cultures, and learning styles.

➢ Prevention and treatment services to protect young minority males from sexually transmitted infections should be widely available. Strategies for appropriate screening of young minority males for chlamydia should be tested and instituted. Special attention should be given to HIV/AIDS due to the disproportionate burden carried by minority males and the social and governmental policies—in the fields of corrections and law enforcement, especially—that help to explain this burden. This special attention should include expansion of community-based approaches and substantial levels of support for projects run by nonprofits.

➢ Health clinics for males and male health programs in community health centers, teen health centers, and family planning clinics should be substantially expanded. Start-up grants, ongoing funding, and third-party reimbursement should support the expansion. New health clinics for males should be located where they are particularly accessible to recently released prisoners.

➢ Community partnerships to promote the health of young minority males should be given priority and supported with state grants. As community resources, community health centers should have central roles in these partnerships. Participation by faith-based organizations and organizations of minority men should also be given priority. The partnership approach should be designed to promote community ownership of the continuum of health protection services for the community's boys and young men of color.

➢Youth development components of the continuum should include preparation for and provision of health-career employment for young minority males, for example, as community health workers, health educators, peer educators, and community advocates. A strategy for youth development through health careers should address, *inter alia*, the following: the value of the training and experience for health protection of young minority males; the contribution of the work to community health improvement, community building, and economic viability of the community; and the opportunities for the jobs to be stepping stones to professional health careers that will help ameliorate the extreme shortage of minority male primary care practitioners.

- ➢ Cultural competence of services, providers, and practices must be of very high caliber, recognizing the enormous diversity within diversity. Specific, long-term, evaluated strategies should be designed and implemented to go beyond the provision of culturally competent care by addressing deep, historically-rooted fear among underrepresented minorities about harm that may be done to them if they make themselves in any way open or vulnerable to professionals and government agencies, particularly in the sensitive, personal, sometimes invasive interactions involved in the delivery of health services.

- Policy, practice, and investment for the continuum must be supported by good and timely data. The story of young minority males' health and well-being must be told and communities must be enabled to tell the story and to make use of data and information for advocacy and community building. A major source of data should be community-based participatory research, and young minority males should be actively included in conducting and using this research. Disaggregations by age, gender, and race and ethnicity must enable the public, communities of color, and policymakers to look at all three factors at once.

PART II: OUTREACH AND ENROLLMENT IN PUBLICLY SUPPORTED HEALTH CARE COVERAGE PROGRAMS

This section outlines four approaches to help ensure that boys and young men of color have publicly supported health care coverage when they would otherwise be uninsured: (1) outreach and enrollment strategies for the State Children's Health Insurance Program (SCHIP) and other programs; (2) Medicaid expansion to the otherwise ineligible uninsured through Health Insurance Flexibility and Accountability (HIFA) Waivers; (3) strengthening and expanding school-based health care; and (4) coverage options for the uninsured. While not strictly a matter of outreach and enrollment, a fifth approach is covered. This is assurance that boys and young men of color who are enrolled in Medicaid receive the full benefits of Medicaid's EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) program for children and youth. The section concludes with recommendations for changes in policy and practice.

Outreach and Enrollment Strategies for SCHIP and Other Programs

The State Children's Health Insurance Program (SCHIP, but also called CHIP) stands out as a program of great promise and high purpose that was undercut by poor enrollment strategies. These strategies put states at risk of having to return unused funds to the federal government while leaving eligible children uninsured. Over time, the program's promise and purpose have been further undercut by caps on enrollment. In its 2003 update on SCHIP, the Kaiser Commission on Medicaid and the Uninsured reported the following findings:

> 3.9 million children were enrolled in SCHIP in June 2003, an increase of 7.3 percent from the previous June. While enrollment increased in 37 states and in the District of Columbia, the number of children covered by SCHIP declined in 13 states. In response to state budget difficulties, seven states have placed caps on enrollment in their SCHIP programs, and 12 of the 30 states that charge premiums or enrollment fees plan to increase the amounts charged in 2004. A handful of states report reductions in eligibility and benefits under SCHIP, with Texas making the most significant reductions in both categories.[53]

The Kellogg Foundation's Community Voices Initiative has compiled a number of enrollment success stories. In West Virginia, for example, mail-back applications were published in newspapers. A governor's cabinet group and the state university system both connected with grassroots organizations that were trusted in their communities and "were provided resources to reach uninsured families in their areas," as the foundation reported in *More Than a Market: Making Sense of Health Care Systems – Lessons from Community Voices: HealthCare for the Underserved*.[54] The coalition approach also connected people on the ground with state policy formulation. This book notes that "[m]ore than 40,000 West Virginia children have been enrolled—93 percent of eligible children in 2001, according to state data."[55] The following are illustrations of the successes *More Than a Market* identifies in other locations:

> Community Voices El Paso also provides leadership to the West Texas Child Health Insurance Program (CHIP) Collaborative, a highly successful enrollment strategy that coordinated local organizations and community links to enroll eligible children in the Texas Child Health Insurance Program.[56]
>
> Drawing together social services providers, area nonprofits, and neighborhood organizations, Denver Health Community Voices is partnering with more than 200 community organizations to reach uninsured

> populations. Six full-time community outreach workers and a corps of trained Medicaid and CHIP enrollment workers link with partner organizations and help streamline access to coverage. In one year alone, the program resulted in 52,000 new applications for Medicaid and CHIP programs for uninsured community members.[57]

When enrollment in Michigan's Ingham County Health Plan reached a plateau, special outreach to the hard-to-reach was instituted. Community health workers were hired to go from door to door in neighborhoods. This tactic was consistent with the two-fold approach of Ingham County Community Voices—namely, covering the uninsured *and* creating a grassroots culture of health promotion, community engagement, and community development.

Outreach and enrollment are tactics not only for covering the uninsured but for preserving community safety-net providers. These providers serve many people who are eligible for coverage but are not actually covered. However, until all patients who are eligible do acquire coverage, these essential providers are at risk—their capacity to serve the uninsured is diminished and they may even go out of existence as community resources. It is not surprising, then, that Denver Health, the public health and hospital corporation for the city and county, has a higher rate of spending on information technology than hospitals in general. Information technology, its CEO says, can have an impact on survival.[58] Like the Ingham County project, the Denver Community Voices project combined community mobilization with sophisticated delivery-system innovation, in this case, an electronic enrollment and tracking tool:

> Denver Health Community Voices has initiated a community outreach program that employs community health advisors from Latino, African American, and Native American communities to connect with hard-to-reach populations. In partnership with the Community College of Denver, Denver Health Community Voices has developed a Certified Community Health Worker curriculum to expand the pipeline of capable outreach workers. In 2000, the Denver Health Facilitated Enrollment program enrolled 74,000 uninsured into coverage options they were eligible for, including Medicaid, the Child Health Plus program, and the Colorado Indigent Care Program. To support the enrollment process, Denver Health developed and piloted AppTrack, an application tracking database.[59]

Beginning in 1999, the State of California and the California HealthCare Foundation joined forces to put the sophisticated Health e-App tool for online enrollment into the hands of community-based organizations, first in San Diego County and, later, statewide. Enabling online signatures, Health e-App has been shown to reduce errors and the time taken to determine eligibility. In 2004, Sam Karp of the California HealthCare Foundation testified before the California Performance Review Commission about the results of this effort as follows: "Here in San Diego County for example, 18 community-based agencies, including community health centers and schools, are actively using Health-e-App to enroll thousands of children each year in the Healthy Families and Medi-Cal for Children programs. Statewide, hundreds of similar agencies are assisting families apply online."[60]

Medicaid Expansion to the Otherwise Ineligible Uninsured through HIFA Waivers

The Secretary of the Department of Health and Human Services has broad authority under Section 1115 of the Social Security Act to waive certain requirements of the act to enable state demonstrations with national significance. The Health Insurance Flexibility and Accountability (HIFA) option authorized by Section 1115 is designed to enable states to extend Medicaid and SCHIP coverage to otherwise ineligible uninsured individuals. The HIFA option also gives states more flexibility to deploy Medicaid dollars in ways that will increase private insurance coverage. A state's strategy to expand coverage must have a neutral effect on the amount of federal money it receives under Medicaid or SCHIP over the five years of the waiver period (with cost inflation factored in for Medicaid). The federal Centers for Medicare and Medicaid Services (CMS) gives the following guidance about the waivers: "HIFA waivers can be funded by savings resulting from service reductions or eligibility changes, by redirecting existing Disproportionate Share Hospital (DSH) funds and/or by using unexpended federal DSH or SCHIP funds."[61] If a state elects to target coverage to mentally ill persons "who meet specific diagnostic or program participation criteria… [DSH] funds that currently support psychiatric institutional services can be used to support a HIFA waiver program."[62]

CMS also reports that, as of February 2005, 10 states had been granted HIFA waivers. Of these, three are jurisdictions given special attention in this paper—California, Illinois, and New Mexico. Advocates for young men of color should take note, especially, of the way the waivers are being used in two of these jurisdictions. Among those to whom Illinois has extended coverage are people with incomes at or below 185 percent of the federal poverty level who are eligible for the state's risk pool because they are uninsurable. New Mexico, CMS reports, "was authorized to contract with managed care organizations to provide a health insurance benefit package that is less comprehensive than the Medicaid benefit package to employed residents with incomes up to 200 percent of the FPL, including childless adults. The health insurance benefit is purchased with state, federal, employer, and employee contributions."[63] (The structure of the New Mexico waiver program, in which costs are shared by government, employers, and individuals, is worth noting. A similar structure can be found in the small business option in Muskegon, Michigan, described in the appendix.) The important fact to note in how HIFA waivers can be (and are being) used is that Medicaid coverage can be extended to adult males who have no children or are non-custodial parents. The categorical nature of the Medicaid program—which has been linked throughout its history to welfare assistance to families in which usually only one parent (typically the mother) is present in the home[*]—has excluded this group of men from eligibility.

Strengthening and Expanding School-Based Health Care

School-based health care brings care to where children and youth are. As a result, it lifts from parents the twin burdens of finding providers in underserved areas and getting their offspring to a care site during its operating hours. School-based clinics assume the responsibility for the longer time it takes to deliver care when parents are not present. And they support families by providing care without regard to coverage or ability to pay. Some clinics are part of or sponsored by hospitals, and school-based health care can be designed to facilitate follow-up care, link their patients into health care systems, and facilitate enrollment in Medicaid, SCHIP, and other coverage.

Healthy Children in Healthy Families: The Role and Power of School-Based Health is a Community Voices Initiative policy brief. Among the topics the brief covers are policy thrusts and funding strategies in states where Community Voices projects are located. The brief reports, for example, on legislative bills on school-based health care introduced, but in most cases not passed, in Florida, New Mexico, and New York.

Two concepts discussed in the *Healthy Children* brief and worth noting are an income-tax check-off for donations to school-based health care and mandates that the state Medicaid and SCHIP programs recognize school-based health centers (SBHCs) as providers. West Virginia made such school-based centers vital components of its sweeping statewide initiative for rural health care, according to the brief: "By 2004, West Virginia had 36 school-based health centers and one school-linked program, serving a total of 46 schools in 19 of the state's 55 counties. These SBHCs serve approximately 25,000 students."[64] The policy brief notes that state and local governments have been the financiers of the growth of SBHCs because a dedicated federal funding stream for them does not exist. The following are other recent developments the policy brief reports:

> In Alameda County, California, the recent passage of Measure A institutes a half-penny sales tax that will generate revenue for Alameda's healthcare safety-net. Of the revenues generated, approximately $1 million is dedicated for school-based health clinics. In New Mexico, Governor Bill Richardson has announced his intention to double the number of SBHCs so that there is at least one in every county. The…Legislature has appropriated $2 million of…[his] request…for capital costs for the new SBHC sites.[65]

Incorporating health promotion into school life is also recommended by the California Adolescent Health Collaborative; SBHCs are one of the means:

> Provide schools with the human and financial resources they need to address the needs of youth by increasing funding for credentialed school nurses, social workers, counselors, credentialed health educators, physical education specialists, school-based health centers, and arts and recreation programs.[66]

Coverage Options for the Uninsured

Medicaid is a means-tested program that also limits eligibility to certain categories of families and individuals. When a low-income young man becomes too old to continue to qualify for Medicaid coverage as a child in a family with dependent children (the welfare-related category), he is usually unable to retain Medicaid through another avenue. He is not likely to be eligible as a father in an intact family with dependent children because he is usually either childless or a non-custodial parent. Nor is he likely to be eligible for Medicaid on the basis of enrollment in the federal Supplemental Security Income program because this requires him to be blind or disabled.[†] If a young man who has "aged out" of Medicaid works and becomes disabled, the Social Security Disability Insurance program and associated Medicare (rather than Medicaid) benefits are still likely to remain out of his reach because his history of paying Social Security taxes will have been too short.[‡] Overall, then, the rules for national public coverage programs are not written with him in mind. Yet many men of color must look to public programs for coverage, due to their disproportionately low income from sporadic employment

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[*] Adult uninsured males with children in intact families may, depending on the policies of the states in which they reside, have access to public coverage through the two-parent family option in Medicaid or the option to expand SCHIP to the parents of SCHIP-insured children.

[†] The Supplemental Security Income (SSI) program gives cash assistance to individuals who are categorically eligible by virtue of being aged, blind or disabled and satisfy the program's criteria for financial need. It is funded with general tax revenues rather than Social Security taxes. To be eligible, a disabled adult must be unable to carry out what is called "substantial gainful activity" due to long-term physical or mental impairment or approaching death.

[‡] The Social Security Disability Insurance (SSDI) program provides income to replace the wages of individuals who have a total and long-term disability and have paid Social Security taxes long enough to qualify (five out of the preceding 10 years or less if under age 31). Certain family members may also be eligible. Two years on SSDI qualifies a beneficiary for Medicare.

or low-wage work without health insurance. The message sent to them by their exclusion from national public coverage programs is that they are not worthy—that they don't count.

Loss of coverage or lack of access to coverage may occur in other ways for young men. Drawing on a Commonwealth Fund study that examines why young people lose health care coverage in the transition to adulthood and what policies can remedy this,[67] *Profile* suggests the strategies of "increasing the cut-off age of parental insurance from 19 to 23 … and targeting college-health plans to provide more services to more part- and full-time students."[68]

During 2004 and 2005, in the absence of either universal health care coverage or larger incremental policy changes to reach the now 46 million Americans who are uninsured, legislation or commissioned studies related to universal coverage were introduced in at least 19 states. Those of particular interest to this paper are California, Florida, Illinois, Maryland, and New York. Illinois established the Covering ALL KIDS Health Insurance Program in 2005. The National Conference of State Legislatures reports that the Illinois program "[provides insurance which covers preventative care, dental and vision, hospital costs, and prescription drugs for all children through age 18 who are not eligible for coverage by Medicaid or the Illinois CHIP. Premiums [are] based on a graduated rate, but all children, regardless of family income, are eligible."[69] In April 2006 the Massachusetts legislature enacted the Health Care Access and Affordability Act, which combines several strategies to secure coverage for all individuals.[70]

Successful local efforts to cope with the absence of universal coverage by creating new coverage options have been more numerous (although they cannot reach as many people as state efforts). These efforts enable localities to extend coverage to groups—such as childless adults, uninsured workers, and people with low incomes exceeding public program eligibility thresholds—that include minority males who are left out of more traditional coverage.

A model of importance to the life pathways of young adult men is San Francisco's Healthy Young Adults program, described as follows by the Adolescent Health Working Group:

> **Healthy Kids & Young Adults.** San Francisco made a bold decision in 2004 to expand its Healthy Kids Program to serve youth to age 25. This public insurance plan provides complete medical care, including preventive and emergency care, hospitalization, dental care, mental health and substance abuse services.
>
> The Healthy Young Adults Program picks up youth 'aging-out' of the children's public insurance programs. In 2010, six years from the program's start, all 19-24 year olds who have aged-out of MediCal [California Medicaid], Healthy Kids, or Healthy Families will have had the opportunity to join Healthy Young Adults. The program also covers 19-24 year old parents with children in MediCal, Healthy Families or Healthy Kids.[71]

The reader's attention is directed toward two Community Voices Initiative policy briefs about local coverage options written by staff at the Economic and Social Research Institute: *Community-Based Health Coverage Programs: Models and Lessons*[72] and *Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity.*[73] Details on programs for individuals and small businesses are offered in a set of tables in the first of these briefs; the tables are reproduced in the appendix to this paper.

These operational coverage options can serve as models for covering minority males and other vulnerable people. More than models is needed, however. The Economic and Social Research Institute authors of the above-cited briefs identify policy options for federal, state, and county policymakers to support community-based health plans. Most important are stable funding and recognition that these plans cannot cover all the uninsured and must, accordingly, be part of larger

State and Local Policy Support[74]

- State law and rules (e.g., for risk-bearing by pilot projects and local use of DSH dollars) can facilitate community coverage plans even without funding them.
- States could fund for start-up, ongoing operations or expansion. Tobacco settlement funds might be used. They could allow creative use of existing state or local funds to leverage federal funds.
- States could expand Medicaid and SCHIP to free up slots in community-based coverage plans.
- State Medicaid agencies could aid outreach and enrollment with, e.g., Medicaid enrollment workers prepared and able to provide information on health coverage for those ineligible for Medicaid and SCHIP.
- State insurance departments could expedite authorization and consider allowing community-based insurance plans to cover more basic benefits irrespective of state-mandated benefits.
- Counties can sponsor plans, help to finance plans others administer, earmark a local tax to fund plans, petition the state to earmark tobacco settlement funds to fund plans, and nurture collaboration among county health departments and community-based safety-net providers.

solutions. The authors' recommended state and county policy options are encapsulated in the text box on the preceding page.

In addition to models and policy support, another factor can be vital to putting alternative coverage in place for the uninsured, including young minority males. This factor is the spirit of community discussed in the section on access above. The importance of the role played by the spirit of community is one reason why the Community Voices Initiative titled the book on the original 13 projects *More Than a Market*. That book recounts a telling story about how two community health centers and other organizations in the Alameda County Access to Care Collaborative worked in community for a greater good:

> One notable collaboration occurred when the group came together to deliver a single message about the allocation of funds from the state's tobacco settlement. "With millions of dollars on the table, the usual approach would be individual organizations positioning themselves for a portion of the amount," Sherry Hirota explains. "But we all came together and said, 'What the county needs most is to expand coverage to uninsured.'" Hirota considers activities like these as evidence of timely collaboration fostered by Community Voices. "By coming together, we adopted a strategy that benefits all of us instead of 'wedge politics,'" says Hirota. "Our core strategy is to stick to a comprehensive approach."[75]

Ensuring Delivery of EPSDT Benefits

The EPSDT program holds special promise to meet health, mental health, and oral health needs because a covered low-income child or youth is entitled to receive any service within the federal scope of services, whether or not the Medicaid plan for adults in the young person's home state includes that service. But actually getting screening, diagnosis, treatment, and rehabilitation services is another thing. Implementation of EPSDT has been troublesome from its beginning. States face litigation from recipients and penalties for regulatory non-compliance from the federal government. Among the ways in which Medicaid is very important for the life pathways of boys and young men of color is in paying for behavioral health services, including services to children in out-of-home placements. Litigation under EPSDT has sometimes been able to trigger systemic reforms in the delivery of these services in states. But a state itself was a losing plaintiff in a suit against the federal government for the latter's refusal to recognize "inpatient residential chemical dependency treatment (to include room and board) as [an] EPSDT rehabilitation service."[76]

Advocates for the EPSDT program argue that its integrity is threatened by recently enacted Medicaid budget cuts. The topic is discussed more fully in Part V, concerning special populations, in part because advocates for foster children are especially concerned. Recommendations for ways to protect the integrity of EPSDT appear both here and in Part V.

Recommendations for Action

In the absence of a national policy for universal health care coverage, states must create universal coverage for all uninsured young minority males and other uninsured young people and other individuals.

- Broad state policy should establish universal coverage within the state's jurisdiction.
    - ➢ One initial immediate step, at a minimum, should be the enactment—as in Illinois in 2005—of coverage for all children through age 18 who are not covered by the state's Medicaid or SCHIP program.
- To support establishing universal coverage and assuring immediate and sustained protection for all eligible young minority males, each state should maximize federal matching dollars to pay for universal coverage.
    - ➢ Accordingly, each state legislature and governor should establish that it is the overarching policy of the state to maximize coverage under existing public programs through intensive and ongoing outreach and enrollment.
    - ➢ The SCHIP program should be fully utilized to expand coverage, and enrollment should not be capped. Increases in premiums and cost-sharing should not be imposed. Benefits should not be cut. Outreach and enrollment strategies that reach hard-to-reach populations should be vigorously implemented. Legislative oversight of implementation should ensure that young minority males are not being blocked from coverage by SCHIP through lax outreach or active thwarting of enrollment.
    - ➢ States should create incentives and supports so that community health centers and other organizations apply "no wrong door" policies, whereby applicants are considered for all programs for which they might be eligible whether or not they qualify for the program that brought them through the door.

- ➢ States should optimize use of presumptive eligibility, create incentives and supports for facilitated electronic enrollment that health care providers and advocacy organizations can use to speed and track enrollment, and support use of outreach workers and enrollment specialists by health care providers, community organizations, and public agencies.

- ➢ The increasing federal opportunities through HIFA waivers should be fully utilized in ways that extend coverage to young minority males, particularly if they are in need of mental health or substance abuse treatment.

- ➢ State policymakers should ensure full use of the Early and Periodic Screening, Diagnosis, and Treatment benefits in the Medicaid program so that this valuable coverage is optimally utilized. Further, state policymakers should back full protection of EPSDT and make such protection the positions of the National Governors' Association and the National Conference of State Legislatures. To the extent that EPSDT benefits are compromised by federal policy (as advocates for children and youth maintain has happened in the budget reconciliation bill adopted in February 2006 for fiscal year 2006), states should appropriate their own dollars to ensure full coverage for eligible young minority males and all eligible youth.

- States should create incentives and supports for start up of coverage options and adopt policy and financing strategies to ensure sustainability of these options.

  - ➢ With state policy and financial support, coverage options for uninsured individuals and for small businesses should be created, following models that are increasingly being adopted in communities.

    - o State law and rules—such as those concerning risk-bearing by pilot projects and local use of Disproportionate-Share Hospital dollars—should facilitate creation of community coverage plans.

    - o States should consider use of tobacco-settlement funds for start-up, ongoing operations, or expansion of community coverage options.

    - o State outreach and enrollment for Medicaid and SCHIP should incorporate information about community coverage options.

    - o State insurance departments should expedite authorization and consider allowing community-based insurance plans to cover more basic benefits irrespective of state-mandated benefits.

  - ➢ Special attention should be given to creating state incentives and supports should be created for options that cover young adults and options that promote access to primary care.

  - ➢ Insurers should be required to make coverage available for young adult children up to the age of 26 who are pursuing higher education through their parents' policies at reasonable cost.

  - ➢ State institutions of higher education should expand health care coverage under their existing programs so that all full-time and part-time students have access.

To increase outreach for health services to young minority males and other underserved groups, all states should adopt and implement policies for vigorous expansion of school-based health care, particularly in underserved urban and rural areas. West Virginia offers a model.

- Funding for school-based health care and incentives (for local authorities, providers, and others) to establish school-based health care programs should not be treated as substitutes for universal coverage or steps in expanding coverage. Rather, such funding should be seen as an investment in the adequacy of the delivery system to meet the needs and improve the health of young minority males and other young people through accessibility to services where they congregate and provision of age-appropriate, culturally appropriate services in welcoming environments.

PART III: MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES: INTEGRATION OF PHYSICAL HEALTH PROMOTION AND CARE WITH BEHAVIORAL HEALTH PROMOTION AND CARE

Each year, more than 33 million Americans receive health care for mental or substance-use conditions, or both. Together, mental and substance-use illnesses are the leading cause of [combined] death and disability for women, the highest for men ages 15-44, and the second highest for all men. Effective treatments exist, but services are frequently fragmented and, as with general health care, there are barriers that prevent many from receiving these treatments as designed or at all. The consequences of this are serious for

Recommendations from *Showing Strength, Overcoming Silence: Improving the Mental Health of Men of Color*[77]

- Reduce stigma through health education and public awareness campaigns.
- Improve access to screening and preventive care.
- Develop cultural and mental health competencies.
- Develop mental health care performance standards for insurers.
- Increase the diversity of the mental health workforce.
- Recognize and support the role of the clergy as an important mental health resource.
- Examine issues related to the availability and appropriateness of medication.
- Develop a coordinated system of care.
- Build the knowledge base on mental health and men of color.

> *these individuals and their families; their employers and the workforce; for the nation's economy; as well as the education, welfare, and justice systems.*[78]

Thus did the National Academies Press speak to the gravity of the impact of these conditions on the health of millions when announcing the 2006 release of *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series* (hereinafter *Improving Quality)*,[79] a follow-on publication to earlier landmark reports, *To Err Is Human* and *Crossing the Quality Chasm*. These sobering facts set the stage for our discussion, which is divided into five sections: mental health services; substance abuse services; co-occurring mental health and substance abuse problems; broad state policy strategy; and recommendations for change in policy and practice.

Mental Health Services

Two Community Voices Initiative publications from 2003 offer a fund of research-based ideas for advocates on the subject of the mental health of minority males. *Showing Strength, Overcoming Silence: Improving the Mental Health of Men of Color* [hereinafter *Showing Strength*], a policy brief, documents and delineates the extent of mental health disorders among men of color (including reasons to suspect undercounting); the importance of good mental health care for these men; the significant personal and institutional barriers to their receiving this care; and the consequences of their receiving no care, delayed care, or inadequate care. *Souls of Black Men: African American Men Discuss Mental Health* [hereinafter *Souls*] is a fact sheet reporting statistics and the conversations of men convened by the Black Mental Health Alliance for Education and Consultation, Inc. *Showing Strength* reports that men of color often lack early preventive or routine treatment, delay seeking treatment (and consequently have more serious problems when they enter care) and receive unequal treatment. Seven barriers are identified: (1) stigma, called the most formidable obstacle to progress

Broad topics and selected recommendations from *Souls of Black Men: African American Men Discuss Mental Health*

In Policymaking:

- Men must speak out.
- Racism must be addressed and social justice promoted.
- "Community-based prevention efforts targeted towards reducing destructive behavior, such as drug or alcohol abuse, must be supported."

In Prevention:

- Send health education by trusted messengers.
- Tailor outreach, promotion, and intervention.
- Intervene early where environment and psychosocial factors predispose men to self-destructive behaviors.
- Address suicide's complex dynamics.

In Community and Provider Education/Service Delivery:

- Respect dignity.
- Involve FBOs, behavioral health agencies, criminal justice system, etc.
- Link academic training and service delivery to promote cultural competence.
- Create formal and informal opportunities for support groups.
- "Conduct stigma awareness training at faith institutions, community organizations, and primary care settings."

on mental health by the surgeon general; (2) lack of support for providers at the entry point of care, specifically a lack of training to enable service providers to identify mental health disorders in minority males, a lack of incentives to ensure proper treatment, and a lack of linkages between clergy (who are lay providers) and clinical mental health services; (3) lack of insurance coverage, which is partly attributable to the types of jobs in which minority men's employment is concentrated; (4) Medicaid's bias in favor of women and children, and the Indian Health Service's bias in favor of reservation residents; (5) lack of parity for mental health services in health benefit design; (6) managed care's bias against physicians who care for underserved populations with life conditions that make their problems more expensive to treat, a bias that "perpetuat[es]… racial and economic disparities in access to mental health care";[80] and (7) the delivery system's bias against people with no or limited proficiency in English. The consequences of all these barriers for men of color include shortfalls in screening and early treatment, higher rates of misdiagnosis, disparate and inadequate treatment, premature death, and the costs associated with all those consequences.

Showing Strength and *Souls* abundantly document how gender, membership in oppressed minorities with disregarded cultures, racial/ethnic stereotyping and discrimination, and socioeconomic status all contribute to the plight of minority males with mental disorders or risks of mental disorders. "Too often," *Showing Strength* says, "men of color view psychological distress and the treatment of it as a personal weakness or failure. They suffer in silence… [M]en may express distress through physical illness, drug or alcohol abuse, and antisocial or other high-risk behaviors (e.g., smoking, gambling, hypertension, [poor] diet, physical inactivity, unprotected sexual activity)."[81] These presenting problems are unlike those typical for women and may mask a man's mental disorder at the entry point to care—which is more likely to be, in the case of men of color, primary care physicians (rather than specialists), clergy (sought out by 40 percent of people with mental health problems), and emergency rooms (where less time for evaluation is given African American males). *Souls* reports the heart-wrenching words of African American men, as these selections show:

> "Racism has caused many of us to believe we don't count and that our needs are not important."[82]
>
> "When we (Black men) don't feel we can provide for our families or protect our children, we feel worthless, depressed and we begin to turn on each other."[83]
>
> "Even when we do everything right and play by all of the rules, we still don't get the respect we deserve, and that is very, very stressful."[84]
>
> "How would you feel if you thought everyone around you was afraid of you, or thought you were getting ready to do something illegal?"[85]
>
> "After they told me, in their way, that I had a mental disorder (after one session) and after only one conversation, I never went back. They didn't care and neither did I."[86]

Recommendations in *Improving Quality* have the potential to bolster the self-esteem of minority males and therefore their confidence in taking charge of any mental health problems they face. For minority males—and indeed for all patients—the patient's dignity, worth, and authority to make decisions would be recognized and respected in the course of treatment under *Improving Quality*'s vision of patient-centered care. For example, informed and patient-centered decision-making would be incorporated into practice and would involve patients in designing treatment and recovery plans; patient preferences in peer support and use of medications would be respected; and payment for programs for peer support and illness self-management would be incorporated into health benefit design.[87]

The recommendations from *Showing Strength* and *Souls* are encapsulated in the text boxes above. Advocates for young minority males could endorse and help disseminate these recommendations while also emphasizing or adding ideas. Four ideas for emphasis or addition are suggested below:

1. Authorities Must Be Trained to View Treatment, Not Punishment, as the First Option

Community authorities in schools, law enforcement, and corrections must be trained to make and be held accountable for making community-based treatment and rehabilitation the preferred alternative to coercion, exclusion, and abandonment of boys and young men of color who are displaying self-destructive or anti-social behaviors.

The actions of school authorities, police, and corrections authorities have enormous impact on the life pathways of boys and young men of color. The principle must be that these authorities must always act with informed, culturally competent, unbiased, and objective judgment and with positive futures for these youth in mind—which they can do without compromising their responsibilities for public safety. The training that authorities receive and the procedures they must comply with should be designed so they can and do act in accordance with this principle.

Background

Souls tells us that young blacks "are more likely to commit suicide after an altercation or perceived victimization by institutional authorities such as the police, criminal justice system, school officials, landlord or welfare department."[88]

Souls recommends improvement of "referral and follow up mechanisms from the criminal justice system to community-based organizations, mental health facilities and substance abuse treatment systems."[89]

Showing Strength contains the disturbing report that "[t]he police are involved in more than one-third of emergency room admissions and this police involvement has been found to correspond to higher rates of involuntary psychiatric hospitalization for men of color."[90]

In *State Public Education Policy and Life Pathways for Boys and Young Men of Color* (herinafter referred to as *Education Policy and Pathways*), also by this author, the section on zero tolerance proposes the following recommendation for advocates to make: "Require referral of students by schools and law enforcement officers to programs that are alternatives to suspensions, expulsions, and arrests in certain circumstances. (A model is the Diversion and Early Behavioral Intervention Initiative of the Baltimore School Police.) Establish a norm of providing substance abuse treatment for children and youth found to possess illegal substances."[91]

The zero-tolerance issue brief also reports the following: "Conduct disorder in boys between the ages of 12 and 17 is associated with carrying concealed guns, and carrying a gun can be considered symptomatic of conduct disorder [citation omitted]. While carrying a gun was explicitly found not to predict violence, the research suggests a preventive—rather than punitive—measure to protect both safety and boys' futures: give boys who either are found with concealed weapons or show signs of behavioral problems caring attention and referral for diagnosis and care."[92]

2. Communities Must Create Environments That Foster Self-Esteem

Community resources must be mobilized to create environments that foster self-esteem in boys and young men of color. Opportunities for positive growth and development and positive contributions to their communities should be widely available to all these youth. Using the anti-stigma health education and public awareness campaign that *Showing Strength* recommends to help stimulate mobilization might make sense. While *Souls* is dealing with African American males, especially adult males of all ages, its concept of community mobilization to support black men in making mentally healthy responses to challenges is more widely applicable:

> Black institutions, community leaders and health professionals must encourage and promote participation and involvement of Black men in both traditional and non-traditional institutional structures, groups and relationships (i.e., churches, family activities, fraternities, health retreats, group therapy, etc) within the African American community that may offer cooperative and self-help approaches to stressful situations.[93]

A key transferable idea in this recommendation is that visible, positional leaders in the community promote participation. This idea is about creating a culture that encourages participation and not simply about having community resources that make opportunities for participation available to people who are interested. Another key transferable idea in the recommendation is to make use of available community resources to open up or expand a particular kind of opportunity—the opportunity to manage stressful situations to minimize their negative impact. When translating this idea to a youth focus, the point would be that this is not just another call for youth development programming but a call for employing the institutional structures, groups, and relationships within the community to support youth in making—and learning how to make—mentally healthy responses to stressors.

The role of community resources in enabling community members to take control of their problems is also explicitly recognized in *Improving Quality*, which counsels providers to "[m]aintain effective, formal linkages with community resources to support patient illness self-management and recovery."[94]

Background

A Kellogg-funded project provides a good story about mobilizing a community's resources of knowledge and tradition to support youth in making healthy choices about substance abuse. The evaluation firm, The Lewin Group, tells the story as follows:

> In a Native American reservation community, a group of elders were concerned about substance abuse among the youth, and the erosion of a connection of the youth to the 'old ways' that were seen as leading to health. In this community on a river, canoeing is an historic activity, integral to the culture. A public health strategy promoted by the elders created a program to teach canoeing and canoe racing. Most youth in the community were recruited to participate. To be in the program, participating youth had to do extensive running and exercise to get into shape, avoid drugs and certain other foods and activities, and canoe every day. Canoeing requires discipline, strength, skill and team work. Trainers pass on the traditions of their ancestors related to canoeing. The youth teams have been so successful, they have gone to international competitions, and problems associated with substance abuse were reportedly minimal.[95]

Another story of men who mobilized as a community resource to model and support healthy life choices is reported in *Education Policy and Pathways*. The program described below is located in a housing project so that the boys participating in it do not have to pass through a gang's territory to reach it.

> Project 2000 began in 1988 with men (including NFL players, plumbers, lawyers, truck drivers, Howard undergraduates, engineers, and bus drivers) serving as teaching assistants one-half day per week [citation omitted]. Because of its success and the enthusiasm of all concerned, it grew into a comprehensive program that is housed outside the schools and features a wide range of mentoring and academic support for African American students in grades one through 12, especially boys and young men.[96]

3. Access to School-Based Health Care

States and localities should ensure that all school-age minority males have access to school counseling and school-based health care, which should include behavioral health services and links to community mental health programs. High-poverty, high-minority schools are inadequately staffed with counselors and social workers and may even have lost staffing they had in the past. While there is increasing interest in school-based health care, the challenges of developing backing, infrastructure and funding flows for it continue to limit its spread. To help overcome these barriers, state and local officials and their national associations should push for adequate federal support for these vital services, which foster integration of primary behavioral health care, prevention, and early intervention into the daily routines of boys and young men of color.

Background

This paper has already identified the value of school-based health care in reaching out to young people to bring them services where they are. A Community Voices Initiative policy brief points out an additional dimension of this value: access to mental health care. As *Healthy Children in Healthy Families* reports, "[a]pproximately 20 percent of children and adolescents have mental health disorders. Yet only 30 percent [of those with disorders] receive treatment."[97] It goes on to say that 27 percent of visits to school-based health centers in Denver and 21 percent of those in New Mexico in 2000 were for mental health care. Substance abuse is also addressed in these centers. For example, Denver centers had nearly 5,000 substance abuse counseling visits in 1999, 58 percent of them involving families as well as students.

The presence of counselors in schools has been recommended as one measure to forestall or defuse student misconduct that leads to suspension or expulsion under current zero-tolerance policies.[98] "[S]chool counselors are specifically trained to identify early warning signs of students' mental, emotional or developmental problems," according to the Judge David L. Bazelon Center for Mental Health Law.[99] Counselors' presence can foster positive school climates and can be considered a "protective factor" in the Hawkins-Catalano or Communities That Care model of prevention supported by the Department of Justice Office of Juvenile Justice and Delinquency Prevention.

The Elementary and Secondary Education Act of 1965 (reauthorized by the No Child Left Behind Act of 2001) is a funding source for school counselors, school psychologists, and other professionals in elementary and, at least theoretically, secondary schools. The problem is gross underfunding. If federal appropriations for this category of services top $40 million, funding can go to secondary schools as well as elementary schools. But grants to states totaled only $11.5 million in fiscal year 2004 and appropriations were only $34.7 million in fiscal year 2005.[100] It is not surprising, then, that a proposed statutory expansion of the support has not seen any action in Congress. *Healthy Children, Healthy Families* reports that proposed legislation would add provisions to current law for even more support to states and school districts—support to help them reach the counselor-to-student and other ratios recommended by the Institute of Medicine. A small new program under the current law supports integration of schools and mental health systems; linguistically appropriate and culturally competent services must be provided.[101]

Guarding Against Inappropriate Diagnoses or Treatment: A Word of Caution

We saw earlier that fear prevents some minority males from seeking care. We need to return to that theme when exploring mental health care. Currently, many young people with mental health problems are not receiving care. There are too few school personnel trained to recognize signs of mental health problems, and the universal mental health screening in schools and other venues proposed by the President's New Freedom Commission on Mental Health in 2003[**] is a long way from becoming the standard practice.[102] Nonetheless, there is already evidence of certain questionable practices in the use of drugs for the mental health treatment of some children and adolescents, part of it pertaining specifically to boys and young men. This evidence raises the issue of whether steps to bring more school-age youth into mental

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[**] The New Freedom Commission envisioned making comprehensive screening and testing a routine, typical, and expected occurrence for both adults and children in settings such as schools and primary care facilities.

health care will have the effect of increasing the number of cases of youth whose treatment is not adequately supported by clinical research. At the same time that advocates promote increased access to mental health care for young minority males, they need to be sensitive to whether legitimate reasons exist for caution—although not fear—on the part of parents and youth in consenting to treatment. *Advocates should push for consistent, monitored use of standards for high quality in screening—to protect, for example, against false positives—and in treatment—to protect, for example, against the inappropriate prescription of drugs.*

Evidence from three sources will be presented: *Improving Quality*; a study of children enrolled in TennCare (Tennessee's version of Medicaid); and experience of a physician-psychologist in private practice. *Improving Quality* expresses concern about the so-called "off-label" use that the clinical literature reports is being made—without good scientific documentation of positive outcomes—of antipsychotic drugs prescribed for children and teens (in general and in residential treatment centers) who are not diagnosed with psychosis but display other problems such as attention deficit/impulsivity, aggression, and conduct disorder.[103]

The study of children enrolled in TennCare was reported in 2004 in the *Archives of Pediatrics & Adolescent Medicine*. A group of doctors at Vanderbilt University examined new prescriptions of antipsychotic drugs for persons ages 2-18. The doctors concluded that "[t]he proportion of TennCare children who became new users of antipsychotics nearly doubled from 1996 to 2001, with a substantial increase in use of antipsychotics for attention-deficit/hyperactivity disorder [ADHD], conduct disorder, and affective disorders."[104] Although this increase was spread throughout the age group studied, the authors further report the following: "The increase was most pronounced for adolescents, for whom the new user proportion more than doubled during the study period. Adolescents had a 3.5-fold increase in new use for ADHD/conduct disorder. During 2001, nearly 1 of every 100 adolescents in the TennCare study population became a new user of an antipsychotic."[105]

Part of the context is that newer drugs were introduced into the market, during the time period covered by the study (1996-2001), that do not have some of the adverse side effects of traditional antipsychotic drugs. While that could justify physicians' greater use of antipsychotics, the difficulty is that the *newer drugs have other side effects, including weight gain and diabetes*. Furthermore, they are being used for ADHD—which is not what they were created for (since ADHD is not a psychosis)—but without high-quality evidence from controlled studies that the prescription of these drugs is suitable for "community-dwelling children."[106] Noting the imbalance between lack of scientific evidence for using atypical antipsychotics in this way for this age group and substantial evidence about adverse side effects, the authors see as urgent the need for research "to determine whether the benefits of this expanded use outweigh the risks."[107]

Leonard Sax, MD, PhD, is a physician-psychologist. His experience in practice was that parents would present him with requests from their sons' schools that the boys be evaluated for the need to be prescribed a drug used to treat attention deficit disorder. Dr. Sax questioned whether medication was always warranted or whether, instead, the problem was how the boys were being schooled.[108] Ultimately, he became an advocate for changing approaches to schooling based on new evidence from brain science about differences in how boys and girls learn.[109]

4. "Transformation": The New Freedom Commission's Agenda

Today, there are opportunities for systemic reform afforded by a new federal action agenda stimulated by the 2003 report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America.* In 2005, state incentive grants were made available to states, the District of Columbia, and tribal organizations for mental health system transformation to improve availability and effectiveness of services. Seven states were awarded five-year grants totaling $92.5 million. Among the seven are three of the 10 jurisdictions of special interest to this paper: Maryland, New Mexico, and Texas.[110] In Washington State, another grant recipient, integration of care, reaching beyond the boundaries of the silos of community mental health, is explicitly recognized as a change demanded by "the vision of the transformation grant."[111]

In addition to taking advantage of these opportunities, state policymakers and advocates for boys and young men of color should look to other federal activities as sources of momentum and thought leadership (if not necessarily funding). Already the majority of states are moving toward evidence-based standards for treatment, following the lead of the recommendations in the Surgeon General's 1998 report on mental health. *Improving Quality* backs coordination or integration of behavioral health care and primary health care to improve the quality of all health care. A federal resource for technical assistance with the health education and public awareness campaigns recommended in *Showing Strength* is the resource center for anti-stigma campaigns of the federal Substance Abuse and Mental Health Services Administration (SAMHSA).[112]

Substance Abuse Services

The Boston University School of Public Health is sponsoring a project called Join Together To Advance Effective Alcohol and Drug Policy, Prevention, and Treatment. Join Together compiles news and information important to advocates and, from 2000 to 2004, funded 28 community advocacy and action partnerships[††] under its Demand Treatment! initiative. Most have continued their strategies to drive up demand for high quality screening and treatment.[113] Join Together calls Demand Treatment! an easily replicable model able to attract federal, state, and other resources including grants from SAMHSA's Drug-Free Communities Support Program Coalition. The model contributes to the community anti-drug coalition movement of more than 5,000 communities.[114] Demand Treatment! helped to spread the practice of addiction screening, brief intervention, and referral (SBIR). Adopting this practice, which SAMHSA grants help to foster, contributes to integrating physical health care with behavioral health care. Demand Treatment! communities learned several lessons about implementing SBIR, according to Join Together news staff:

> Establishing successful addiction…[SBIR] in primary-care settings requires good training, establishing effective liaisons between primary-care staff and addiction experts, and ensuring that you're adding as little as possible to the staff's existing workload.
>
> But keeping SBIR programs going requires "buy-in" from primary-care partners, good outcomes data and…money, according to experts [at a local Demand Treatment! meeting on lessons learned].
>
> …[A] licensed social worker for Wishard Health Services,[*] one of the community health clinics participating in the Indianapolis Demand Treatment! project, said the addiction professional who comes to his clinic twice a week (for about two hours at a time) not only acts as a resource for staff, but also can meet with clients directly. "You need to have that connection" in order to involve the clinic in the development of the SBIR program, rather than imposing a screening protocol from above.[115]

In addition to funding communities, Join Together has convened national Demand Treatment! policy panels. It collaborated in 2002 with the American Bar Association (ABA) on the Discrimination Policy Panel. The ABA carried the work further, calling, for example, for a change in state insurance laws that effectively bar emergency room doctors from screening and referral of patients for alcohol problems. In 2005, ABA members appeared before the bipartisan House Addiction, Treatment, and Recovery Caucus[†] with statements opposing drug-abuse policies that discriminate and stigmatize, such as policies that deny cash, food, housing, and educational assistance to ex-offenders.[116]

Broad community strategies were the interest of another Join Together panel, this one on Treatment Quality Improvement Policy. Join Together recently convened the Blueprint for the States Policy Panel, which is charged to consider state financial and organizational structures and policies that would support substance abuse prevention and treatment most effectively. One concern is that most substance abuse agencies have lost cabinet-level status over the past 15 years (a sign of diminished priority) although states spend millions on the problem.

The National African American Drug Policy Coalition mentioned earlier also has much to offer advocates for young minority males. It seeks the reallocation of dollars from punishment to prevention and treatment, and it promotes *pretrial diversion and therapeutic sentencing* as methods for combining drug treatment with alternatives to incarceration. Three sites where it is targeting efforts —Chicago, Baltimore, and Washington, D.C.—are in jurisdictions of interest to this paper. "Effective treatment will reduce the number of crimes which would otherwise have been committed by these individuals, thus making the community safer and reducing the costs of law enforcement and the courts which would have been expended in connection with new crimes," said Arthur L. Burnett, Sr., the national executive director of the coalition, in a 2005 press release.[117]

This paper earlier discussed a continuum of health protection services and strategies for young minority males ranging across medical care, public health, youth development,

A Note on Substance Abuse Intervention and Cultural Sensitivity[118]

Primary care providers need cultural competence to provide SBIR. A project director with Community Voices of Northern Manhattan had this to say: "It's really sensitive. We're dealing with an increasingly culturally diverse minority population, with a limited number of providers that want to understand the culture and really develop the level of trust that would ensure clear observation and communication in order to say that something's wrong."

[††] Eight communities are in jurisdictions of interest to this paper: California, Florida, Illinois, Maryland, New York, and Texas.

[*] The reader will note that Wishard Advantage, a coverage option, is described in the appendix.

[†] The caucus formed in 2004 and its 2005-06 membership consists of 78 representatives. Seven jurisdictions of interest to this paper are represented: California, Florida, Illinois, Maryland, New Mexico, New York, and Texas.

Youth and the Alcohol Industry[119]

"Youths who are frequently exposed to beer ads in grocery and convenience stores are more likely to start drinking, according to research from the nonprofit Rand Corp.," Join Together reports.

"The alcohol industry's warnings to our kids not to drink until they are 21 are buried under an avalanche of alcohol ads that glamorize drinking," Join Together also reports, quoting the director of the Georgetown University Center on Alcohol Marketing and Youth.

and community development. Information from the Join Together Web site reinforces the concept of public health protection from environmental factors that are inimical to health. Whether or not they are valued by the power structure as human beings, young minority males are certainly valued as consumers, so protecting them from commercial inducements to harm their health is vitally important. Public health anti-tobacco campaigns have had success. Public health efforts should also protect youth against the allurements put forth by the alcohol industry (see text box).

Commenting on a new study by university researcher Snyder and her colleagues, the director of Georgetown University's Center on Alcohol Marketing and Youth, David Jernigan, links youth drinking to the amount spent per capita for alcohol ads in a local market and observes that "[t]here is ample evidence that youth across America are consistently seeing and hearing more alcohol advertising per capita than adults on TV and radio and in print."[120] His center stresses that the study "conclude[s] that greater exposure to alcohol advertising contributes to an increase in drinking among underage youth. Specifically, the analysis shows that for underage drinkers, exposure to one more ad than the average for youth was correlated with a 1 percent increase in drinking, and that an additional dollar spent per capita on alcohol advertising in a local market was correlated with a 3 percent increase in underage alcohol consumption as well."[121]

Co-occurring Mental Health and Substance Abuse Problems

A Man's Dilemma: Healthcare of Men Across America—A Disparities Report, a 2004 Community Voices publication, reports that "29 percent of individuals with a mental disorder also have a substance abuse disorder, 37 percent of individuals with an alcohol disorder also have a mental health disorder, and 53 percent of individuals with a drug disorder other than alcohol also have a mental disorder."[122]

In 2001, the Federation of Families for Children's Mental Health published *Blamed and Ashamed*, reporting findings from a SAMHSA-funded study "to document and summarize the experiences of youth with co-occurring mental health and substance abuse problems and their families."[123] Interviews or focus groups were held with 150 youth ages 13-28 and their parents, including residents of greater Washington, D.C., California, Georgia, Illinois, and New Mexico (all jurisdictions of interest to this paper), as well as four other states. Chosen for racial, ethnic, and socioeconomic diversity, the young people had all lived in both substance abuse treatment facilities and mental health treatment facilities. Residential treatment is relevant to this paper because, in addition to being less likely to receive mental health treatment than non-Hispanic white men, men of color are underrepresented in outpatient treatment and overrepresented in inpatient treatment (where less educated men are also overrepresented).[124]

Blamed and Ashamed recommends that providers listen attentively to youth and families, inform them and involve them in decisions, and educate and prepare them for the post-treatment period. Two points deserve special notice:

- "*Create opportunities for youth to help others in treatment and afterwards.*"[125] This is consistent with the aim of the National Initiative to Improve Adolescent Health by the Year 2010, namely that health improvement approaches be inclusive, collaborative, and innovative, and view youth as assets. *Blamed and Ashamed*'s companion recommendation to youth is to *"[a]sk to mentor or help other young people with problems."*[126] (Youth are also counseled to, *inter alia*, to speak out about what they need, educate themselves about what prompts regression, and know their own weaknesses.)

- "*Focus on the length of time the youth needs treatment instead of the length of time a family is able to pay for services or their insurance is willing to cover it.*"[127] Another publication of the Federation of Families, in partnership with the Judge David L. Bazelon Center for Mental Health Law, is *Staying Together: Preventing Custody Relinquishment for Children's Access to Mental Health Services*.[128] This advocacy guide addresses a common state policy forcing families to relinquish custody to the child welfare system when public or private insurance will not cover intensive mental health treatment.

Although the recommendations in *Blamed and Ashamed* are directed toward SAMHSA, a federal agency, some are relevant to state policy. Funding of youth peer-to-peer outreach and network development is recommended, for example, as is funding of what are called "multi-stakeholder processes." The tasks of these latter processes are threefold: (1) identifying information that youth and families critically need; (2) promoting "collaboration between the substance abuse and mental health systems, agencies, and providers"; and (3) developing and disseminating "guidelines for providers to insure services for youth with co-occurring mental health and substance abuse disorders are fully integrated and effective."[129]

Broad State Policy Strategy

Mental health and substance-use disorders kill and impair. Attention to disorders among the young is crucial because, in 75 percent of cases, mental illness emerges while a person is young, while early adulthood is a peak time for drug use. The leading causes of death for young men of color, according to *Profile*, are motor vehicle accidents, homicide, suicide, and AIDS, and all of these are bound up with mental health and substance abuse problems. Mental health disorders, addiction, and risky use of substances can be detected and effectively treated. But in our nation, the person experiencing such a problem is more likely not to receive treatment than to receive it. Given that the human, social, and economic costs of these afflictions are so tragically and astronomically high, and given the substantial know-how we have developed for detecting and treating them, why are rates of treatment so disproportionately low? Among the reasons we have seen are stigma attached to mental illness; fear directed toward providers and their cultural insensitivity toward patients; discrimination against drug offenders; lack of sufficient public and private financing for treatment; lack of sufficient training, infrastructure, and protocols for primary care providers to detect problems; and lack of sufficient numbers of K-12 school personnel with training in mental health.

Advocates for boys and young men of color can combine advocacy for specific policies with a push for the adoption of strategies in three broad areas to *create infrastructure, ethos, and resources to bring what is known to bear on what is done*. Specific policies and larger strategies would be complementary. Ideas for specific policies have been distilled into the text boxes that appear below, at the end of the recommendations for action that follow. Discussed here are three possible priorities for strategic action to leverage change: (1) state and local organizational structure and initiatives; (2) practice reforms; and (3) financing.

1. *Organization and Initiatives:* Responsibility, visibility, and accountability should be housed at the state level in a focal point for supporting—and monitoring results from—a comprehensive, multi-faceted, multi-level, and multi-sectorial initiative for financing and delivery of prevention and screening for all, as well as early intervention and treatment for mental health disorders and substance abuse for all who need them. Like the National Initiative to Improve Adolescent Health by the Year 2010, a state's initiative should cross sectors and levels, employ a range of approaches, engage youth, and involve community organizations and professionals. The concept of the health protection continuum of medical care, public health, youth development, and community development for young minority males should be applied in the initiative. As is typically the case with complex problems, no single state agency has all the necessary roles, authority, and resources. A focal point responsible for interagency coordination may help, but accountability for producing results is equally important. Elected officials—governors and legislators—and the people who elect them have to hold the person or office at the focal point accountable. To set and enforce the standard for what the focal point is accountable for, legislative caucuses and legislative hearings should identify results sought and keep track of progress made. With respect to the executive branch, Join Together clearly believes that the drop-off in cabinet-level status of substance abuse agencies has reduced responsibility, visibility, and accountability. It will be important to see what its national Blueprint for the States Policy Panel proposes.

   Advocates for young minority males can enunciate principles about what the organizational infrastructure and initiative proposed in this paper should accomplish. High on the list should be responsibility for the following: (a) focusing on boys and young men of color; (b)monitoring and reporting need vs. treatment by age, gender, socioeconomic status, geographic location, and race/ethnicity; (c) establishing standards, training, and monitoring to ensure cultural competence, high quality, and non-discrimination in prevention, screening, and treatment; (d) tracking and reporting the impact of post-punishment denial to nonviolent drug offenders of access to educational and other benefits; and (e) seeding and supporting Demand Treatment!-type community-based initiatives that receive coordinated financial, organizational, policy, and technical assistance support from state agencies.

   Demand Treatment! offers a model for local organizational infrastructure and initiative design. A virtue of combining local organizing and action with state work is that the local partnerships act not only as catalysts for local planning and implementation but also as constituents and advocates for continuing state commitment and change.

2. *Practice:* Mental health and substance abuse treatment should be integrated to serve those with co-morbidities better. Mental health and substance abuse organizations should collaborate on prevention, early intervention, and treatment strategies, such as infusing mental health support into substance abuse services. Screening, brief intervention, referral (SBIR), and follow-up for mental health and substance abuse problems should be integrated into primary care, and this integration should

be supported with financing, training, evaluation, and infrastructure. Providers must be trained and expected to provide services in ways that are culturally appropriate to patients. Patients must be engaged in setting direction for their treatment and—particularly in the case of youth—in peer-to-peer support. The venue for practice must be seen as extending into schools, which must be staffed with frontline mental health professionals, that is, with enough counselors, social workers, school-based health care givers or other helping professionals trained in mental health to serve as the frontline for SBIR and case-following for the nation's school-age youth, especially boys and young men of color. In light of research findings about trends in the prescription of antipsychotic drugs to children, state quality standards and clear information to parents and patients must be mandatory accompaniments to the introduction of widespread screening.

3. *Financing:* Just as "location, location, location" are the top three priorities in real estate, perhaps the three top priorities here ought to be "financing, financing, financing." If the financing were there, many desirable innovations would follow. As it is, financing is grossly inadequate to meet need, much of which goes unmet. Marketplace and public policymakers need to grasp the following: (a) how much it costs to fail to intervene and treat; (b) how much total public and private financing is needed to meet the need for intervention and treatment; (c) why parity pays; (d) how much well-supported primary prevention, regulatory strategies, and public health communications campaigns would cost; and (e) how much intervention and treatment costs could be lowered, over time, by such prevention, regulation, and communications. Finally, these policymakers and the public need to know the direct and indirect lifetime costs of unprevented and untreated mental health and substance-use disorders in boys and young men of color.

Full and comprehensive parity has long been the call of private advocacy groups such as the National Mental Health Association, and the Institute of Medicine has added its voice to the call in *Improving Quality*. The National Mental Health Association reports that 34 states have some form of parity law[130] but only the laws in Connecticut, Maryland, Minnesota, Vermont, and Oregon are models of best practice.[131]

The opportunities for doing business in a new way afforded by federal HIFA waivers could be the platform for building a comprehensive funding policy. It is, therefore, important that some state and local voices are being heard and actions taken with a broader perspective about financing:

- Iowa Attorney General Tom Miller has again called for dramatic spending increases on substance abuse treatment as the number one way the state could fight crime. The request for 2006, which the Iowa House Speaker was skeptical about despite increased revenues, was for $17 million. Among the uses would be services to prison or jail inmates and probationers.[132]

- In September 2005, the county mental health director urged the Jefferson County, Washington, commission to support a 0.10 percent excise and sales tax increase to expand drug court programs and treatment for chemical dependency and mental health disorders. The director said, "All law enforcement has clearly stated that if mental illness problems went away, that would cut their load by half," according to a local news reporter.[133]

- Ann Christian, CEO of the Washington State Community Mental Health Council, reported the following to her constituency: "The 05 Legislative Session ended, and immediately became known as the 'Session of Mental Health.' Three major pieces of mental health policy legislation, 1290, 5763 and Mental Health Parity, were passed along with a remarkably supportive budget, replacing $80 million of the $82 million in lost federal funds."[134]

Recommendations for Action

- State policymakers should enact a broad strategy for state and local organizational structure and initiatives to leverage systemic change.

    ➢ Each state should mount a comprehensive, multi-faceted, multi-level, and multi-sectorial initiative for financing and delivery of prevention and screening for all and early community-based intervention and treatment for mental health disorders and substance abuse for all who need them with a focus on boys and young men of color, community-based partnerships to build infrastructure for local systems change, and involvement of community-based and faith-based organizations.

    ➢ Design of each initiative should be built around the concept of a health protection continuum for young minority males of medical care, public health, youth development, and community development and should include youth engagement and standards, training, and monitoring to ensure cultural competence, high quality, and non-discrimination in prevention, screening, and treatment.

    ➢ Each initiative should seed and support community based anti-drug coalitions (such as Demand Treatment! partnerships) that (a) receive coordinated financial, organizational, policy, and technical support from state agencies and (b) serve as catalysts for both local-level systemic change and state-level systemic change.

- ➢ A state-level focal point at the cabinet level should be responsible and accountable for the initiative. It should support and coordinate the interagency and multi-level work and report the results, which should be monitored through legislative and gubernatorial oversight. The focal point should track (a) need vs. treatment by age, gender, socioeconomic status, geographic location, and race/ethnicity and (b) the impact of post-punishment denial to nonviolent drug offenders of access to educational and other benefits.

- Further, state policymakers should enact a broad strategy for practice reforms with the following features:
  - ➢ Continuum of services: Practice should be organized to support an array of services in a continuum of promotion, prevention, early detection, treatment, and support for recovery without relapse.
  - ➢ Integration: Mental health and substance abuse services should be integrated to serve those with co-morbidities better and to infuse mental health support into substance abuse services.
  - ➢ Screening through primary care: Screening for mental health disorders, brief intervention, referral (SBIR), and follow-up should be integrated into primary care. Training, incentives, and infrastructure should support this integration. State standards for mental health should ensure the highest quality and protect against discrimination and detrimental labeling.
  - ➢ Staffing schools for mental health support: Schools should be appropriately staffed for the ongoing provision of SBIR and follow-up. State standards for quality and anti-discrimination should be applied in this setting for screening also.
  - ➢ Culturally competent services: Training, standards, and incentives should support the provision of culturally competent services throughout the continuum.
  - ➢ Patient engagement: Patients must be engaged in setting the direction of their care. Especially in the case of youth, patients should be resources for the care of others through peer-to-peer support.

- State policymakers should, further, enact a comprehensive investment strategy for financing implementation of the other strategies. The resources necessary should be provided by:
  - ➢ Facilitating reallocation (through new budget architecture) of resources from areas such as law enforcement, corrections and detention, adjudication, and commitment of juveniles, where savings accrue—or are projected to accrue—to spending on prevention, screening, and treatment, with emphasis on community-based treatment.
  - ➢ Taking full advantage of opportunities for federal funding or matching of expenditures, including opportunities for HIFA waivers and EPSDT services that are not restricted by new federal cost-saving measures for Medicaid.
  - ➢ Making it easier for local jurisdictions to reallocate resources so they can contribute to the initiative, in light of the savings that will accrue to their law enforcement and other local functions from effective prevention and treatment of mental health disorders and substance abuse disorders.
  - ➢ Drawing in private resources through the enactment of mental health parity laws for private insurance, modeled after laws in Connecticut, Maryland, Minnesota, Vermont, and Oregon. To be full and comprehensive, state laws should cover all mental health disorders and all substance abuse disorders and apply to all employers without exemption. They should also require that mental health benefits do not have lower annual and lifetime spending caps, lower limits on days and visits, or higher co-payments and deductibles than physical health benefits.

- State legislators should conduct hearings and oversight to develop and implement strategies in which the following matters are laid out: (a) how much it costs to fail to intervene and treat; (b) how much total public and private financing is needed to meet the need for intervention and treatment; (c) why parity pays; (d) how much well-supported primary prevention, regulatory strategies, and public health communications campaigns would cost; (e) how much intervention and treatment costs could be lowered, over time, by such prevention, regulation, and communications; and (f) the direct and indirect lifetime costs of unprevented and untreated mental health and substance abuse disorders in boys and young men of color.

- State policymakers should, in addition to enacting the three broad strategies, adopt the specific policies proposed by advocates and experts that are summarized in the text boxes below.

Specific Policies[135]

Join Together encapsulated what policymakers can do:

- Limit alcohol advertising and promotional activities that target young people… [A] 2000 survey found over 60 percent of Americans support reducing alcohol ads on television, billboards, and at sporting events.
- Require and enforce equal insurance coverage for drug and alcohol treatment.
- Make screening for alcohol and drug problems a routine part of every primary care and emergency room visit.
- Require effective treatment and continuing, supervised aftercare programs instead of incarceration for nonviolent drug and alcohol offenders.
- Support the work of community coalitions. Communities that have a written strategy to reduce alcohol and drug problems report greater citizen involvement, more constructive public policy change, better access to treatment, and increased diversity of funding sources.

Specific Policies

Policy options identified in this paper include:

- Use of community-based substance abuse treatment per a RAND study (see Juvenile Justice System section on page 39).
- *Showing Strength* favors anti-stigma campaigns, better access to prevention, cultural competence, performance standards for insurers, workforce diversity, support for clergy, medication policy review, care coordination, research on men of color.
- *Souls* supports tailored outreach, prevention, and early intervention; addressing suicide's dynamics; cultural competence; involving faith-based organizations; fostering support groups; stigma awareness training in communities; prevention of substance abuse; and criminal justice system referral to community treatment.
- Train and require authorities to choose treatment over punishment.
- Mobilize community resources for youth self-esteem; fund youth peer-to-peer outreach.
- Expand coverage for mental health (or other) care through HIFA waivers.
- Fund school-based early intervention, referral, and follow-up for mental health problems.
- Use federal grants for mental health system reform.
- Stop forcing families to relinquish custody to obtain mental health care for their kids.

PART IV: ACCESS TO HEALTH CARE PROFESSIONALS AND SERVICES (INCLUDING MENTAL HEALTH) THAT REFLECT THE CULTURAL AND RACIAL COMPOSITION OF THE COMMUNITY

This section has four parts. First, it explores the groundwork for action laid by the Institute for Medicine and the Sullivan Commission. Next, it explores ways to lower barriers that young minority physicians encounter to actually entering practice (as opposed to entering and completing formal training). Its third topic is designing policies to lower these barriers. It concludes with recommendations for action.

Groundwork for Action Laid by the Institute for Medicine and the Sullivan Commission

In *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, the Institute of Medicine reported on the lower quality of health care received by minority patients even when insurance status, income, and other factors related to access are controlled for. The 2003 publication recommended, *inter alia*, that the share of health professionals who belong to underrepresented minority groups be increased.[136] The problem was recently summarized by Louis Sullivan, MD, president emeritus of Morehouse School of Medicine and former Secretary of Health and

"A Health System Modeled on Excellence, Access, and Quality for All People"
The Sullivan Commission's Three Principles[137]

1.) ***To increase diversity in the health professions, the culture of health professions schools must change.*** Our society is experiencing a significant and rapid demographic shift. The culture of our nation is changing. So too must the culture of our health institutions. As colleges, universities, health systems, and others examine these recommendations, they must also examine the practices of their own institutions.

2.) ***New and nontraditional paths to the health professions should be explored.*** In some health professions, it takes between 10 and 12 years to fully educate and train a provider. This Commission calls for major improvements in the K-12 educational system, with the realization that the degree of diversity in health professions schools cannot remain stagnant while these improvements take shape.

3.) ***Commitments must be at the highest levels. Change can happen when institutional leaders support the change***. In 1966, Duke University School of Medicine was one of the last two medical schools in the South to admit a black student. Today, Duke University School of Medicine has become a model of diversity and has used its leadership to bring other institutions along a new and inclusive path toward excellence.

Human Services, as follows: "While African Americans, Hispanic Americans and Native Americans make up more than 25 percent of the U.S. population, they represent only: 9% of nurses; 6% of physicians; and 5 percent of dentists."[138] Headed by Dr. Sullivan, the Sullivan Commission was established in April 2003 with a Kellogg Foundation grant to identify and understand the barriers to workforce diversity and propose solutions. Dr. Sullivan explains that it aimed for "*a comprehensive national strategy* to promote diversity through immediate and long-term interventions, long term systemic and institutional change, and potential legislation to sustain momentum toward diversity in medical, educational, and policy areas…[and also sought to] examine the presence and nature of *institutional social contracts* between health professions education schools/programs and the communities to whom they are accountable [emphasis in original]."[139]

In *Missing Persons: Minorities in the Health Professions*, published in 2004, the Sullivan Commission made 37 recommendations founded on three principles (see text box). The thrust of the recommendations in *Missing Persons* and *Compelling Interest*, as summarized in a presentation by Dr. Sullivan, is shown in the next two text boxes.[140] Also funded with a Kellogg Foundation grant in the same time period was the Health Professions Diversity Committee of the Institute of Medicine. This committee's 2004 report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, considers strategies at the institutional and policy levels and identifies ways to garner support for implementation from key stakeholders, including leaders in the health professions and community members.[141]

The Sullivan Alliance: Transforming America's Health Professions was formed to spearhead implementation of the recommendations in *Compelling Interest* and *Missing Persons*. Its partner is the Health Policy Institute of the Joint Center for Political and Economic Studies. Early signs of progress reported by Dr. Sullivan include (1) the formation in September 2004 of the Virginia-Nebraska Alliance (of which Dr. Sullivan is president and chairman) and (2) the formation in January 2005 of the Commission to End Health Care Disparities by the American Medical Association, the National Medical Association, and the National Hispanic Medical Association.[142] The Virginia-Nebraska Alliance brings together *both* majority institutions of higher education *and* Historically Black Colleges and Universities (HBCUs) in Virginia with the University of Nebraska Medical Center, which made its first formal HBCU affiliation with Dillard University in New Orleans in 2001.[143] The Virginia-Nebraska Alliance, its Web site reports, "provides a multitude of academic and research opportunities for minority undergraduate students and faculty."[144]

From the perspective of advocates for boys and young men of color, the Sullivan Alliance's efforts to boost the numbers of minority health professionals practicing in underserved communities should both increase the health care access of young minority males and, if implemented with this in mind, create career opportunities for them. Advocates, then, have an interest in backing the work of the Sullivan Alliance and in informing implementation by stressing the importance of special strategies—in light of the educational gender gap for minority males—to recruit boys and young men of color into the health professions.

Two stories about the Virginia-Nebraska Alliance help illustrate the challenge of males' participation in increased workforce diversity. First story: State Senator Benjamin J. Lambert III, a black Virginia physician-lawmaker who has worked on higher education funding, has been helping to recruit all the state's HBCUs to partner with the Nebraska university. Although he knew it was true, a *Washington Post* article reports, the senator was shocked to hear that "[t]he nation's predominantly white medical schools accepted only 70 black men in 2003."[145] Second story: Summer interns in the Alliance

What Is Needed to Increase Workforce Diversity and Cultural Competence

From the Sullivan Commission on Diversity in the Healthcare Workforce

- LEADERSHIP from all sectors.
- HEALTH PROFESSIONS SCHOOLS' accountability for diversity and cultural competence of graduates.
- ADMISSIONS POLICIES redesigned.
- MULTILINGUAL COMPETENCE enhanced.
- STUDENT AID substantially increased; more scholarships, loan forgiveness, tuition reimbursement.
- ACCREDITING BODIES foster change.
- PRESIDENT has advisory group for national approach.

Five Areas for Strategic Action from the Institute of Medicine's *In the Nation's Compelling Interest*

- Admissions policies and practices of health professions education institutions.
- Public (e.g., state and federal) sources of financial support for health professions training.
- Standards of health professions accreditation organizations pertaining to diversity.
- The "institutional climate" for diversity at health professions education institutions.
- The relationship between Community Benefit principles and diversity.

program from Virginia are studying in Nebraska. Dr. Sullivan and Dr. Lambert visit with them. *Of the six African American undergraduate interns, only one is male.*[146]

Advocates who are interested in community strategies to improve the health and well-being of young minority males may be intrigued by the fact that the Sullivan Commission explored the concept of social contracts between health professions education institutions and communities. Advocates might consider developing a scenario such as the following:

Minority legislative caucuses and community-based or faith-based organizations or advocacy groups form alliances around design and implementation of policies that set expectations for the production, placement, and successful entry into sustained practice of minority primary care practitioners (physicians, advanced-practice nurses, and physician assistants).

Barriers to Entering Practice in Communities of Color: Closing the Loop

Advocates for minority communities can propose to state policymakers that they put together a package of strategies to support practice by minority health professionals in communities of color. In other words, to complete the career pathway created by building health career awareness, encouraging math and science course-taking in high school, and changing public and institutional policies for recruitment and admission into health professions training, *post-training stepping stones have to be in place as well.*

Graduation or completion of post-graduate training does not make all the barriers on the career pathway melt away for male and female minority practitioners and does not determine that they will be able to practice in the communities to which they are most drawn. A news story from southern New Jersey makes the following point, for example: "Establishing a financially balanced patient base that treats well-insured and underinsured patients may…be more difficult for minority physicians…[P]atients across the board tend to choose doctors of similar ethnicity, and a greater percentage of black and Latino patients are covered by low-paying plans."[147] One established minority physician interviewed for the story says this kind of challenge is hurting his area's efforts to retain doctors, particularly those of color. "I've had the privilege to talk to student doctors, and the majority of them aren't planning on staying here."[148]

The reporter also tells the story of a second-year black male medical student from an impoverished community who, based on his family's and neighborhood's experiences, "plans to develop a wraparound social services center that would provide family and mental health care, child care, door-to-door transportation for clients, food vouchers and other services."[149] What are the things that could hold him back from setting up this practice in his home community? The barriers identified in the article include the following: (1) very low Medicaid reimbursement rates in his state; (2) especially high malpractice insurance rates; (3) high rates of uninsurance among the underserved patient-base he is interested in; (4) high education loan indebtedness; and (5) comparatively high cost of living in the area. (Note also that, in a study in a different state, a factor found to influence the decision to stay in practice [rather than enter it] was the penetration of managed care.[150])

The cost of setting up a practice combines with these barriers to create a "challenge [that] can be particularly unsettling for physicians of color," according to the private practitioner interviewed for the article, who is also president of an area medical association for African American physicians. He sees that "many African-American and Latino medical students don't feel they have professional mentors of similar background whom they can turn to for advice about setting up shop," an opportunity that helped him greatly during his own residency.[151]

What are possible solutions? How can new minority male professionals be brought into practice where the need is most dire? A starting point for state policymakers is a study by the National Conference of State Legislatures. A reading of *Practice Location of Physician Graduates: Do States Function as Markets?*[152] suggests it is important to design or redesign policy around the facts and circumstances in the particular state and its underserved regions. A general template may not work. The following are three important lessons suggested by experience in the field:

1. Several factors bear on whether physicians who are trained in a state—either in medical school or in residency—are retained to practice in that state. For example, whether the state has a large population is associated with whether medical residents trained there stay there. Among the other factors thought to matter are median household income, population density, and the size and number of medical schools and graduate medical education programs.

2. "A majority of generalist physicians and physicians in metropolitan areas practice in the same state where they completed their most recent GME [graduate medical education]. Although most states do not retain a majority (or import a minority) of their total physicians, some states fare better than others. Seventeen states retain at least half of all physicians who completed their GME in state."[153]

3. Going to a public medical school in one's home state, then choosing a residency in that state, and then choosing to practice in that state appear to be linked, even though there is no single pattern that applies to all states. This linkage suggests that, to increase access for the underserved, it could be more feasible for a state to enlarge, market, and create incentives for GME programs (especially in medically underserved settings) for in-state medical school graduates than to increase medical school capacity.

Designing Policies to Lower Barriers to Practice in Communities of Color

Advocates for young minority males should give attention to the following considerations for the design of policies:

• *Health professions education institutions' influence on location of practice*

The Sullivan Alliance's position that health professions education institutions should be accountable for admitting and graduating increased numbers of minority group members could be extended—specifically, it could be extended to holding institutions accountable for influencing minority and other graduates' decisions about practice in underserved areas. A "soft" version of extending accountability is the expectation for gathering and reporting information. For example, an idea of the American Association of Colleges of Pharmacy is that its member institutions survey their pharmacy graduates, especially minority graduates, about the type and location of practice and report the results as a tool for minority recruitment.[154] The study from the National Conference of State Legislatures (NCSL) reports on what might be called "hard" versions of extending accountability:

> Several states stipulate that a high percentage of newly entering students to public medical schools be state residents. With access to primary care in HPSAs [Health Professional Shortage Areas] a persistent problem for most states, many public medical schools require students to complete a family practice clerkship, and some state-subsidized family medicine training programs offer residents a rural rotation. A few states have laws that mandate training programs to institute some or all of these requirements.[155]

• *More and stronger incentives to practice in low-income and minority communities*

The NCSL study reports changes in the policy landscape: "Major payments for GME that most states make through their Medicaid programs, second only in size to Medicare's contribution, are threatened by cost controls under managed care. States increasingly rely on loan repayment programs, tax credits, practice development subsidies and other strategies, in lieu of scholarships, to encourage small numbers of graduating physicians to practice primary care in HPSAs [citations omitted]."[156] The rising cost of malpractice insurance suggests one type of stronger incentive. Physicians who are making decisions about where to practice need the benefit of public policies intended to protect them from the high costs of medical malpractice insurance. Another type of incentive would be to guarantee a certain level of income by directly providing dollars.

• *Incentives for solo and institutional practice*

Incentives must respond to differences in supports needed for solo practice and practice through, or as an employee of, an institution such as an academic medical center or a community health center. Practice through an academic program may attract young minority practitioners as an alternative to incurring the costs of private practice.[157]

• *Guaranteed mentoring by professionals in practice and training for practice*

Mentoring about setting up practice can lower barriers. States could appropriate funding to pay practitioners who mentor new professionals. Payments would be both incentives and recognition of the time mentors are away from earning their livings and caring for patients in their own practices.[‡] Programs for medical students and residents to learn about the economics of private practice and other important issues minority physicians face should be instituted and available for all who are interested. One model is a program of the Massachusetts Medical Society Committee on Diversity in Medicine, which uses practicing internists and other specialists.[158] Comparable programs should be available to minority advanced-practice nurses and dentists who are in training for independent practice.

• *Sharp targeting*

State policymakers should be asked to respond with sharp targeting to the emerging calls for increasing the number of medical school graduates by 15 percent by 2015 and increasing the associated number of residency positions. This increase would be equivalent to 16 new medical schools and 2,500 additional graduates of allopathic medical training per year, the American Medical Association reports.[159] Who will be trained and who will receive the benefit of the increased supply? One answer to that question is suggested by a paper on retaining underrepresented minority Californians trained in medicine, authored by researchers at the University of California Program on Access to Care:

> The Charles R. Drew/UCLA Undergraduate Medical Education Program was established in 1978. The program is administered by the Charles R. Drew University of Medicine and Science (Drew), which is located in an impoverished area of Los Angeles with a predominantly African-American and Latino population. Drew's mission is to educate health professionals who intend to practice in medically underserved communities and to provide care to disadvantaged populations. Students enrolled in the Drew/UCLA Medical Education Program complete the first two years of basic science courses at the UCLA School of Medicine. The last two years of clinical education are completed at Martin Luther King, Jr., Medical Center, a public hospital affiliated with Drew, and a community health center.
>
> The Drew/UCLA program has been highly successful in recruiting underrepresented minority medical students. Underrepresented minorities constituted 75% of entrants to the Drew/UCLA program in 1999, a much higher percentage than that of any other medical school in California [citation omitted]. At present the program is quite small, with approximately 25 first-year students admitted each year. Given that California has an ample overall supply of physicians with pockets of underservice in inner-city and rural areas, increasing enrollment in the Drew/UCLA program is a prudent approach to addressing the state's physician workforce needs. Increasing the size of the entering class of the Drew/UCLA program would significantly increase the cadre of physicians likely to provide care to underserved populations.[160]

• *Fundamental decisions about the structure of economic opportunity*

U.S. medical schools annually produce fewer graduates than the number of residency slots in the nation, thus creating openings for International Medical Graduates (IMGs).[161] A number of IMGs are trained in their home country of India for the express purpose of coming to the United States to practice. Meanwhile, African Americans, Native Americans, and Hispanic Americans who are here face numerous barriers and disincentives to health careers. It is certainly true that use of IMGs spares the United States the cost of undergraduate and graduate training of physicians. Is this the time to rethink policy on IMGs and investments in health workforce education? Is this the time to reallocate resources to diversifying the health workforce through greater participation of underrepresented U.S. minorities, with special attention to the barriers faced by young minority males?

• *Community engagement with institutions*

The range of incentives to practice in minority communities could include the development of partnerships for the health career pipeline that forge community-institutional connections with multiple benefits.The W.K. Kellogg

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[‡] This is an especially important point. In the academic environment a common experience of minority medical school faculty is to be expected to sit on every committee for which minority representation is thought to be good, give special attention to as many minority students as possible and, in general, help with every cause related to the status of minority medical professionals. The demands to be "the representative" can be hugely taxing—and worse, potentially damaging to career advancement, which calls for putting time into research and other activities that do not involve volunteering to help others. The reason is that most schools have only a handful of minority faculty (especially those who have tenure or are on the tenure track), which leaves any given individual with a large share of the responsibility.

Foundation has extensive experience with community-institutional partnerships for building the pipeline and health professions education. In one partnership in rural Tennessee, in communities where out-of-hospital sites were created for training medical and nursing students together, the residents became vocal constituents who expected the medical school dean to retain the program. More high schoolers in the community applied to the university after witnessing the young professionals in training in their community. Ultimately, the university and several communities built an entire system of care sparked by a training program. At the site in Boston, a health professions education grant led to several lasting changes. For several Federally Qualified Health Centers, community engagement became a way of doing business. In addition, a nursing school reoriented teaching and practice toward practice in out-of-hospital community sites. In another Boston project seeded by Kellogg, 14 community health centers are partners in building the pipeline. The centers' partners in the Health Careers Academy, a charter high school, include the Boston Public Schools, the Boston Public Health Commission, the college of medicine at Boston University, the school of health sciences at Northeastern, and Boston Medical Center.[**]

Recommendations for Action

- Advocates for young minority males should endorse full and prompt implementation of *Compelling Interest* and *Missing Persons* strategies and back the Sullivan Alliance in its efforts. These strategies are essential for increasing young minority males' access to culturally competent health care and increasing their career opportunities. Further, advocates should call for special strategies and attention to meet the challenge of recruitment and retention of underrepresented minority males.

- State and institutional policymaking should help develop community leadership to enable linkages between underserved communities and *both* health care institutions *and* health professions education institutions around these institutions' roles and responsibilities in increasing diversity in the health workforce.

    ➢ Minority legislative caucuses and community- and faith-based advocacy groups should work in alliance to design and oversee the implementation of policies that set expectations for the production, placement, and successful entry into sustained practice in underserved communities of minority practitioners—especially male practitioners—in primary health, oral health, and mental health care.

    ➢ Policy should make these institutions accountable for increasing workforce diversity, with special attention to young minority males. Community direction-setting mechanisms and leadership should be incorporated into the institutions' accountability for producing community benefits through workforce diversity.

    ➢ Public and institutional policy should foster community-institutional-school partnerships for K-20+ pipelines to health careers for young minority males. These partnerships should support the full length of the pipeline from early health career awareness to setting up practices. They should enable communities to "grow their own" professional health workforce. In addition to covering the more traditional health occupations, these pipelines should include opportunities for practice as community health workers, especially in areas of particular concern to young minority males, and career ladders for young minority male community health workers.

- States should create packages of strategies to support underrepresented minority health professionals, especially males, in establishing and sustaining practices in low-income communities of color. Special attention should be given to incentives and supports for young minority male professionals to return to their home communities to practice.

    ➢ The strategies should be responsive to the factors and circumstances in different communities and states that affect decisions to establish and maintain practices – factors such as cost of living and cost of malpractice insurance. The use of subsidies for development and sustainment of practices should be considered. Practice support should respond to needs of professionals in both solo practice and practice in institutions (academic health systems, community health centers, public health clinics).

    ➢ Strategies in use in some states—such as tax credits and loan repayment—should be examined by other states for their efficacy and applicability.

    ➢ Medicaid reimbursement rates should be raised, and financial incentives should be provided to ensure that practice in underserved communities will be economically viable. Incentives might take the form of guaranteed salary floors for practice in institutions or payments to practitioners in solo or group practice designed to enrich reimbursement for serving large numbers of Medicaid and uninsured patients.[††]

[**] The reader may note that the Boston Medical Center and the 14 affiliated community health centers are the partners in Boston HealthNet, a coverage option described in the appendix.

[††] These payments would be somewhat analogous to DSH (Disproportionate-Share Hospitals) payments.

  - ➢ Policy should institutionalize and financially support the mentoring of new practitioners by professionals in established practice and the education of medical and other students and residents in practice economics and related matters.

- Workforce diversity—with special attention to underrepresented minority males and the needs of underserved, low-income communities of color—should be the top priority in federal and state policymakers' responses to the emerging calls to increase the number of medical school graduates. Professional and institutional organizations—such as the Association of American Medical Colleges—and their members that call for change should be challenged to demonstrate unequivocally that (a) health professional shortage areas and medically underserved areas will be shrunk or eliminated with investment in production of more physicians; (b) the surge in production will be used to bring the proportion of physicians who belong to underrepresented minorities to equitable levels; and (c) special and efficacious attention will be given to recruitment and admission of young minority males to the new openings.

  - ➢ Debate on the response to proposals to increase the supply of physicians should explicitly address the structure of economic opportunities implied by the gap between the annual number of U.S. medical school graduates and the number of residencies for new graduates.

PART V: ACCESS TO HIGH QUALITY PHYSICAL AND BEHAVIORAL HEALTH SERVICES WITHIN THE CRIMINAL JUSTICE, JUVENILE JUSTICE, AND FOSTER CARE SYSTEMS

Criminal Justice System

Statistics on incarceration cover both prisons and jails. "[O]n any given day 2.2 million people are incarcerated in the United States, and over the course of a year an estimated 13.5 million individuals are confined in prison or jail for some period of time," reports the Commission on Safety and Abuse in America's Prisons, a group established in 2005.[162] The U.S. Department of Justice estimates that in 2002, 635,000 persons were released from prison.[163] For jails, a group of researchers in urban and community health provides the following information:

> On June 30, 2003, a total of 691,301 inmates were in jails in the United States, an incarceration rate of 238 per 100,000 residents and an increase of 46% from the 1990 rate. Of these inmates, 88.1% were male and 11.9% female; 43.6% were White, 39.2% Black, 15.4% Hispanic, and 1.8% some other race/ethnicity.[164]

The right to health care while incarcerated is founded on the U.S. Constitution's prohibition of cruel and unusual punishment and its guarantee of substantive due process. But corrections systems throughout the nation fall far short of meeting even basic health care needs. Offenders enter with more health problems than are found in the general population and can exit still sick or sicker still, taking infections and other health risks back to the general population while facing no guarantee of health care at all for themselves, no matter what their medication or other health needs are. Advocates for health care in prisons believe the criminal justice system is failing to live up to the constitutional guarantee. At the same time, as we have seen, health care coverage for working-age minority men outside prison is so grossly restricted that society's unspoken message to them seems to be, "prison is the only place you have a right to care, however poor the care may be."

The public health threat from grossly inadequate correctional health care has been summarized by researcher Restum as follows:

> US citizens face a growing threat of contracting communicable diseases owing to the high recidivism rate in state and federal prisons, poor screening and treatment of prisoners, and inferior follow-up health care upon their release.[165]

If care in prison is substandard, care after prison is worse. Today's parole system, largely supervisory in nature and non-supportive and having few links to health care, is being challenged for its counter-productive effects. Thus, an Urban Institute roundtable on prisoner re-entry heard a call for a new parole model, one where supervision is community-centered, parole violation has an intermediate sanction other than re-incarceration, and substance abusers receive intensive treatment.[166]

The work of the Community Voices Initiative on men's health through the National Center for Primary Care has recently concentrated on correctional health care, which it has featured in fora and in the October 2005 issue of the *American Journal of Public Health*. Salient facts, problems, and proposed solutions identified by researchers and advocates and reported in this policy education campaign include the following:

- Infectious diseases spread in the crowded conditions of many prisons and jails,[167] adding to the reasons why they are dangerous places. Studies show that:

  - ➢ Infectious disease is four to 10 times more prevalent among prisoners than among the general population;[168] and

  - ➢ While under two percent of Californians in general are infected with hepatitis C, more than 41 percent of inmates in California are infected.[169]

- Mental illness is common, affecting 60 percent of inmates.[170]

- Correctional systems are home to 3.8 percent of all reported cases of tuberculosis (TB). Between 1993 and 2003, the TB case rate in the general population was 6.7 per 100,000, but in federal prisons it was 29.4 per 100,000, and in state prisons it was 24.2.[171]

- The gap between the need for substance abuse treatment and receipt of treatment is very large. For example, while 73 percent of inmates in New York state prisons need such treatment, only 33 percent participate in substance abuse programs.[172]

- Many states have sought to save money by contracting with private providers or correctional HMOs such as the nation's cheapest provider of prison medicine, Correctional Medical Services.[173, *]

- The ability to avoid re-offending and re-arrest is compromised for prisoners with chronic disease or mental illness who lose access to needed medications upon release.[174]

- A "study of 1,426 homeless and 'marginally housed' adults found that 23.1 percent had a history of imprisonment. Among those, jail or prison time was also associated with a higher risk of cocaine use, mental illness, HIV infection and having had more than 100 sexual partners. Homeless people who had been imprisoned also were most likely to currently be selling drugs."[175]

- One small study suggests "that certain service types—health services in particular—may be important in facilitating successful transition from prison to the community."[176] It further suggests that diverse other services may also help; their impact should be assessed in larger, longer controlled studies.

- A study of community re-entry among adolescent males and adult females from New York City jails identified barriers and supports such as:

  - ➢ Association of health insurance with lower rates of re-arrest, and
  - ➢ Association of drug- or alcohol-related problems with a rate of re-arrest three times higher than that of released individuals without these problems.[177]

- Despite the thinking behind the proposed federal Second Chance Act of 2005, "[w]ithout modification of federal and state policies, the ability of reentry services to foster behavioral health and community reintegration is limited."[178]

- One solution would be to extend Medicaid coverage to former prison and jail inmates.[179]

- The nation could save billions of dollars a year by improving health care in prison and after release.[180]

The National Commission on Correctional Health Care has also compiled data. It cites estimates that the number of people behind bars in 1997 who were infected with HIV was between 34,800 and 46,000 (including 8,900 AIDS-infected persons); with STIs, between 107,000 and 137,000; with hepatitis B, 36,000; and with hepatitis C, between 303,000 and 332,000.[181] The commission reported to Congress that "[d]uring 1996, about 3 percent of the U.S. population spent time in a prison or jail; however, between 12 and 35 percent of the total number of people with selected communicable diseases in the Nation passed through a correctional facility during that same year."[182]

Another horrific reality of incarceration—abuse and neglect—further threatens health and well-being. This side of prison life is under study by the Commission on Safety and Abuse in America's Prisons.[183] Co-chaired by former Attorney General Nicholas Katzenbach and former Third Circuit Court of Appeals Chief Judge John Gibbons, the Commission held four field hearings in 2005 and 2006 and aims to inform broad public dialogue with information about serious abuses and safety failures in correctional facilities and their effects on inmates, on the communities they return to, and on correctional officers and their families. Testimony on correctional health care was taken at the July 2005 hearing.

What strategies are being pursued to improve correctional health care? The National Commission on Correctional Health Care (NCCHC)[†] and the American Correctional Association accredit health care programs, which are not legally

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[*] The *New York Times* ran a three-part exposé based on a year-long investigation of the services in New York of a commercial provider, Prison Health Services, which has contracts in 28 states. Titled "Harsh Medicine," the series by Paul von Zielbauer ran on February 27 and 28 and March 1, 2005.

[†] The NCCHC is supported by 38 major national health, law, and corrections organizations. Such organizations coalesced around an initiative of the American Medical Association begun in the early 1970s that evolved into the National Commission in the early 1980s. The Commission's purpose is to improve the quality of health care in prisons and jails as well as facilities for the detention or commitment of juveniles. In addition to accreditation of facilities, it provides standards; training; certification credentials, information, and publications to correctional health professionals; and position statements on issues. It also conducts conferences and commissioned studies.

required to receive any accreditation. The activities of the two organizations are vital to quality assurance, but the fact that accreditation is not mandatory is a massive barrier that, combined with underfunding of correctional health care, substantially blocks the achievement of quality.

While voluntary accreditation standards do not exert much pressure on states for improvement, the experience in Illinois shows that pressure can come from the costly consequences of failing to provide good correctional health care. Faced with the highest rates of recidivism in its history, Illinois innovated a new model of drug treatment in prison. It re-opened the Sheridan Correctional Center to make it the largest prison in the U.S. reserved solely for drug offenders.[184] In 2004, Sheridan began to implement an approach that showed such promising results after just one year that an Urban Institute expert opined it could, by combining proven strategies into one program, be a model for the nation.[185]

The approach at Sheridan is an intensive treatment program. One academic researcher who studied the recidivism rates among prisoners released from the facility found that, first, recidivism for the group studied was 12 percent compared to 27 percent for released prisoners who had been incarcerated elsewhere and, second, the comparison for a subgroup that had served at least seven months at the facility and in other prisons was no rearrests versus 20 percent recidivism.[186] How does the program work? "Each week…[prison] officials work with outside organizations to give inmates nearly 50 hours of drug and alcohol counseling and other therapy sessions, education, job training, and additional skills to prevent recidivism."[187] The Urban Institute expert counseled that state authorities need also to involve communities in aftercare by helping with continued treatment and jobs.

Rather than treatment *during* incarceration, treatment *instead of* incarceration is a prime policy target of the National African American Drug Policy Coalition. The coalition is promoting therapeutic sentencing, which judges use to substitute treatment for prison time for persons guilty of certain drug crimes.[188]

The National Association of State Mental Health Directors surveyed its members about activities in their jurisdictions that accorded with the thrust of the recommendations of the President's New Freedom Commission. Several activities are germane to advocates for young minority males who are concerned with state policies:

> Colorado has a legislative "Oversight Committee on Persons with Mental Illness in the Criminal Justice System, which has resulted in the testing and implementation of youth and adult screening instruments. The implementation of these instruments has included partners in state government and the private sector."[189]
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> Maine has a joint mental health and corrections plan for action on inmates of jails and prisons with mental illness and substance abuse. In addition to state and local law enforcement and corrections officials, the National Alliance on Mental Illness and a legislative Commission to Address Sentencing Issues are involved. "Mental Health courts are being explored [in the state]."[190]
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> Diversion from the criminal justice system and re-entry to the community are the aims of a collaboration in Rhode Island that engages state departmental directors. One target is the "presence of community providers at [the] state prison to facilitate intake/discharge for behavioral health clients."[191] State and local behavioral health agencies, state corrections, and a supported housing corporation are involved.

Juvenile Justice System

The following offers a look at three issues concerning the health of youth who are in the juvenile justice system or at risk for juvenile delinquency: (1) health care for juveniles with mental health and substance abuse disorders, including community-based alternatives to lock-up; (2) Medicaid coverage of juveniles leaving the system; and (3) mortality of delinquent youth after involvement with the juvenile justice system.

Health care for juveniles with mental health and substance abuse disorders, including community-based alternatives to lock-up

"The most recent annual estimates from the US Department of Justice show that there were 2.2 million juvenile arrests in 2003 and approximately 1.1 million individuals referred to juvenile courts," write researchers at the Psycho-Legal Studies Program at Northwestern University. "More than 104,000 juveniles are held in juvenile placement facilities on a given day. Over 60 percent are racial/ethnic minorities."[192] Mental health and substance abuse disorders are widespread among these youth and go far to explain why they get into trouble. The Northwestern University researchers say, for example, that "[e]pidemiological studies estimate that between two thirds and three quarters of detained youths have one or more psychiatric disorders. More than 15 percent of detained youths have major mental disorders (e.g., affective disorders, psychosis) and associated functional impairments."[193] Their own study was of nearly 2,000 juveniles in detention ages 10-18. They found that only 15.4 percent of those needing treatment received it at the facility and only an additional 8.1 percent more received it in the community.

Despite the large gap between need and treatment, facilities for juveniles are actually being deliberately and extensively used to house youth needing treatment. In its 2005 annual report, the Federal Advisory Committee on Juvenile Justice asserts that "[t]he juvenile justice system has become the primary placement system for youth needing mental health services" and reports the finding that "thousands of children are incarcerated in juvenile detention centers only because they are waiting for community mental health services [citation omitted]."[194] It recommends alleviating the problem by allowing states to use Medicaid to pay for home- or community-based services as an alternative for juveniles placed in confinement.[‡]

When youth with serious mental illnesses act out, their antisocial behaviors may violate the law and lead to detention or commitment in facilities ill-equipped to provide treatment for the underlying causes of their misconduct. Untreated, they remain at risk for repeating the behaviors, and typically bounce in and out of juvenile detention. An alternative that works has been found, according to a December 2005 *Morning Edition* story by NPR reporter Michelle Trudeau: "Each year, more than 1.5 million youth enter the juvenile justice system. Experts say a large percentage of these teenagers are mentally ill, but rarely receive proper treatment. Some juvenile courts have been created to take teens with severe illnesses out of the mainstream juvenile justice system."[195] Juvenile mental health courts are meant for the approximately 200,000 cases per year in which intensive mental health care is needed. The county court in Santa Clara, California, featured in NPR was established with redirected money rather than new money, an important fact advocates stress in order to overcome the resistance to establishing mental health courts. Since its founding in 2001, about 130 youth have transferred voluntarily from juvenile detention to the court's supervised program in which they live at home, sometimes under house arrest. The criteria for selection of cases are strict—for example, the teen must have severe mental illness—as are the rules for the teen, who must stick to a regimen of intensive mental health therapy, attend school and community service, obey a house curfew, wear an electronic monitoring bracelet, and be tested regularly for drugs. The recidivism rate in a recent year dropped to about 10 percent, the broadcast said, far below the national average for juvenile offenders. A psychiatrist who helped found the court stated that about 60 percent of juvenile offenders have some form of mental illness and about 20 percent have biologically-based disorders such as bipolar disorder, schizophrenia, and severe depression. He has seen children hallucinating in solitary cells where they were left for days because, even when juvenile detention facilities have doctors, they usually don't have the time and expertise to handle these cases.

"Early, accurate identification of youth with mental disorders in the juvenile justice system is a critical need," opined Robert Flores, administrator of the federal Office of Juvenile Justice and Delinquency Prevention in 2004. "Once identified, these youth can receive the services required to improve their lives, reduce recidivism rates, and promote community safety."[196] The authors of a guide for practitioners published by the Office, Grisso and Underwood of the National Center for Mental Health and Juvenile Justice, recommend the best practices of universal screening and more detailed assessment where indicated by the youth's condition.[197]

Treatment alternatives to punishment are also available for teens with substance abuse problems who get into trouble. In September 2004, the journal *Psychology of Addictive Disorders* published the findings of a carefully controlled study by the RAND Corporation, a research organization. RAND viewed their finding as "the first clear evidence" that "community-based drug treatment programs can reduce substance use and improve psychological health."[198] Teen probationers in a residential "therapeutic community" program of drug treatment, 12-step support, and mental health counseling used drugs less both during and after the residential portion of treatment than matched teen probationers in comparison programs. They also had better psychological health than their peers in the comparison, who underwent probation in detention centers, camps or other placements where the focus was not on treating substance abuse.

Several models of community-based approaches are presented in the accompanying text box (see next page).

Medicaid coverage, medications, and referral for services for juveniles leaving the system

Researchers who studied Medicaid policy for juvenile offenders concluded that youth leaving detention or commitment facilities[**] will fare better if they are given supplies of their prescribed medications to take with them and if any Medicaid coverage they lost upon confinement has been restored so that they have a card in hand to use for treatment of health and behavioral health problems.[199] Depending on the particular state's response to the federal prohibition on Medicaid's paying for services to the incarcerated, a youth may have been disenrolled from Medicaid or suspended from Medicaid. Suspension makes resumption of Medicaid coverage faster and is recommended by the federal government.[200]

The most intensive juvenile casework should be provided to youth leaving detention and commitment. Case management would include referral for mental health and substance abuse services and assurance of their provision. A framework for assuring that a young person released from detention or

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[‡] This would be done by expanding the authority of the Secretary of Health and Human Services to grant waivers to states under § 1915 (c) of the Social Security Act.

[**] Youth may be leaving detention facilities where they have been awaiting adjudication of their cases—and where their stays are typically shorter—or they may have been committed to correctional facilities.

Models of Community-Based Approaches[201]

Chester County, Pennsylvania: The average age of youth in the United States who have diagnosed mental health problems and are arrested for the first time is 14. Responding to this fact, a Chester County, Pennsylvania, model program of interagency cooperation provides an array of services to youth on psychiatric medication who take it irregularly or use substances for self-medication.

Muskegon County, Michigan: A state-funded pilot project for collaborative, countywide planning and assessment involved the state public health institute, local family court, county sheriff's department, and the Family Coordinating Council (FCC) and helped to spearhead a comprehensive strategy for youth in Muskegon County, Michigan. The many programs encompassed by the strategy include the following:

> "Violence Intervention Program (VIP) and Behavior Control Intervention Treatment (BCIT) – Programs are targeted at students who have demonstrated aggressive behavior. This program works with teachers and parents, as well as the students. The program is based on Arnold Goldstein's Aggression Replacement Therapy, a best practice model program, and Adventure Therapy, an experiential learning model. These programs are a collaboration between Muskegon Area Intermediate School District, all 12 public school districts in the county and Child and Family Services of Muskegon."
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> "Services to Expelled Students Program – Is a program providing outreach to expelled students in the county in an effort to return them to school. This addresses both academic needs and behavioral problems. Both students and parents receive services. It is a collaborative effort between Muskegon Area Intermediate School District, all 12 public school districts in the county and Child and Family Services of Muskegon."
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> "Latinos Working for the Future – A Muskegon County-based advocacy organization, partnered with the FCC to design outreach, advocacy and prevention programming for Latino youth and seniors."

The Muskegon Community Health Project, which developed one of the coverage options described in the appendix, developed a software program in use in several counties called SHOnet. SHO stands for Serious Habitual Offender. "The SHOnet software program allows communities to coordinate real-time case management of at-risk youth in their own communities, as opposed to high-cost residential treatment or the use of jails. Care coordination is jointly managed by community partners through a secure Internet site."

Baltimore, Maryland: Substance Abuse Systems, Inc., a branch of city government, manages treatment for addictions. About 1,700 teenagers were treated in 2004, most referred by the court system to the city's treatment programs. Arrests for this group went down by 77 percent, employment and education went up by 68 percent, and the retention rate for youth who went back to school or work was 89 percent.

commitment receives the full panoply of health and other services that are needed is the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders of the Justice Department's Office of Juvenile Justice and Delinquency Prevention.[202] A key feature of this strategy is for states to establish a system of graduated sanctions. Lock-up is the most severe. The platform for the strategy is the Hawkins-Catalano social development theory, which also underlies the Communities That Care delinquency-prevention program funded by the Department of Justice. In this theory, *protective* factors in the domains of individual/peer, family, school, and community are intended to enable youth to overcome risk factors through resiliency. The ability of protective factors to beat out *risk* factors has been demonstrated by research. The period following release from lock-up is a crucial time to surround a youth with protective factors to help break the cycle of recidivism—or, as the NPR story put it, the "bouncing in and out" of the juvenile justice system.

Mortality of delinquent youth after involvement with the juvenile justice system

Researchers who were examining health needs of juvenile delinquents discovered during the course of their longitudinal study that the young people in their study population were dying at disturbingly high rates, far out of line with the death rates of their peers in the general population.[203] They were not dying from physical disease but from trauma, usually as victims of homicide or legal intervention rather than suicide. Even a death in an auto accident was a victimization: the youth was run over by a rival gang member. During the time researchers tracked them (an average of seven years), 65 out of 1,829 young people who had been involved with the juvenile justice system died, a rate the researchers report is four times higher than in the general population and is comparable to a total of 52 deaths from school shootings among all U.S. school children over 10 years (although it is only school shootings that are publicized). The highest mortality rate in the group was for young African American males.[204] Involvement in the juvenile justice system is, therefore, associated with increased risk of early death by violence. Among other things, this means that the juvenile justice system has an opportunity, indeed a duty, to intervene in these young people's lives to reduce risks and increase their chances for long, healthy, productive lives.

When interviewed, Linda Teplin, the principal investigator, made a provocative point: The population of young people who report (in research surveys) that they have engaged in delinquent behavior is much more racially and ethnically diverse than the population of young people who are brought under the jurisdiction of the juvenile justice system (see text box).[205] Whether a misbehaving youth whose misbehavior is detected is brought under the system's jurisdiction depends on a series of discretionary decisions by authorities that affect the youth's fate. These decisions determine whether the young person will come into contact with the juvenile justice system at all and, if there is contact, whether he or she will be locked up.

> ***Let's remember: self-reported rates of delinquency aren't all that different when it comes to race or ethnicity. What's different is who winds up in the juvenile justice system. The kids in the system are disproportionately racial or ethnic minorities. Sixty percent are African American, Hispanic or some other minority. And these kids are at great risk for poor outcomes.***
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> — Dr. Linda Teplin, principal investigator in a study tracking youth who had been in the juvenile justice system, as quoted on the Robert Wood Johnson Foundation Web site.

School principals, for example, may or may not decide to call in the police when a student misbehaves. In school or out, a police officer may or may not decide to arrest (or issue a summons to) a youth with questionable behavior. An arrested youth may be released without referral to juvenile court. An arrested youth referred to juvenile court may or may not be detained while awaiting court processing. In court, a youth may or may not be adjudicated (that is, judicially determined to be delinquent), and an adjudicated youth may or may not be committed to a correctional facility.[206] This winnowing down could be said to create a population of the most vulnerable, a population of young people, disproportionately minority and disproportionately male, needing the most ongoing health protection from the continuum of health services for adolescents and young adults. The death rates discovered by the researchers who were looking for something else signal the danger in a tragic way.

Foster Care System

Nurturing relationships with adults are essential ingredients for young people's healthy development. But too many youth and young adults experience barriers to consistent supportive relationships. National data are reported on those children in foster care whose placement, care, or supervision are state responsibilities. The data show that large numbers of children are in foster care, where many remain for years, and black children are overrepresented while white children are underrepresented. More than a half million children are in foster care on any given day: the number estimated nationwide by the U.S. Children's Bureau on the last day of September was 552,000 in 2000 and 518,000 in 2004.[207] The following are the estimates from the U.S. Children's Bureau[208] for the last day of September in 2003 for the jurisdictions of interest to this paper:

California	97,261
Washington, D.C.	3,092
Florida	30,677
Georgia	13,578
Illinois	21,608
Maryland	11,521
Mississippi	2,812
New Mexico	2,100
New York	37,067
Texas	22,191

The federal agency reports important details about the composition of the population of children in foster care on September 30 of each year (the end of the federal fiscal year). For example, the mean number of months that children counted in 2003 had spent in foster care was 31, while the median was 18. At that point in time, 5 percent had been in foster care for less than one month and 16 percent had been there for five years or more. The preliminary total estimated was 523,000 children. Non-Hispanic black children were overrepresented in this group: they made up 16 percent of U.S. children, yet *35 percent* of those in foster care. By comparison, the proportion of Hispanic children in the child population (19 percent) is close to their proportion in foster care (17 percent). Non-Hispanic white children, in contrast, were underrepresented in foster care: they made up 62 percent of U.S children, but only 39 percent of those in foster care. Finally, the smallest group comprised American Indian or Alaskan Native children who are non-Hispanic.[209]

Health, developmental, and other problems for children in foster care are well summarized in a document by Child Trends, a nonprofit organization devoted to research in behalf of children, as follows:

> Children in foster care are more likely than other children to exhibit high levels of behavioral and emotional problems. They are also more likely to be suspended or expelled from school and to exhibit low levels of school engagement and involvement with extracurricular activities. Children in foster care are also more likely to have received mental health services in the past year, to have a limiting physical, learning, or mental health condition, or to be in poor or fair health.[210] One study found that almost 60 percent of young children in foster care, ages 2 months to two years, had a high risk for developmental delay or neurological impairment.[211]
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> Foster children who age out of foster care instead of returning home have an accumulated set of problems that make a successful transition to adulthood difficult. According to the only national study of youth aging out of foster care,[212] 38 percent were emotionally disturbed, 50 percent had used illegal drugs, and 25 percent were involved with the legal system. Educational and career preparation was also a problem for these youth. Only 48 percent of foster children who had 'aged out' of the system had graduated from high school at the time of discharge, and only 54 percent had graduated two to four years after discharge. As adults, children who spent long periods of time in multiple foster care homes were more likely than other children to experience problems such as unemployment and homelessness [endnotes in the original].[213]

About 20,000 youth age out of foster care each year. The needs of former foster youth identified by the Adolescent Health Working Group and partner organizations that advocate for youth in San Francisco include the following: "Youth transitioning from foster care have disproportionately high rates of physical, developmental, and mental health problems, and many do not access needed medical care due to lack of health insurance and high health care costs… Former foster youth in a recent study suffered post-traumatic stress disorder (PTSD) at rates twice as high as for U.S. war veterans."[214]

Ensuring that children and youth in foster care have access to the health and mental health services that will meet their needs

Medicaid is the essential source of coverage for children in foster care. Recent work on the federal budget put the adequacy of Medicaid coverage for children in jeopardy, according to advocates. On October 17, 2005, before decisions on the final budget bill had been made, Casey Family Programs, a single-issue foundation, released *Protecting Children in Foster Care* [215] (prepared for it by a group of health and legal experts) in response to proposals to cut Medicaid from the National Governors' Association, the National Conference of State Legislatures, the Administration, and the Medicaid Commission.[††] The analysis found that a number of proposals would harm children in foster care. By the time the budget reconciliation conference report was staged for a final vote in early February 2006, the Center for Budget and Policy Priorities included the following in its assessment of harm to children on Medicaid in general:

> Under the conference report…the vast majority of children enrolled in Medicaid, including those below the poverty line, could effectively lose access to the comprehensive health care coverage they now are guaranteed through the Early and Periodic Screening, Diagnostic [sic] and Treatment (EPSDT) component of Medicaid. The conference agreement allows states to provide scaled-back benefit packages to children, as long as the states that do so "wrap around" those scaled-back benefit packages so that overall coverage remains available for the same health care services that currently must be made available under EPSDT. This approach is unlikely to work well in practice, however: examination of how "wrap-around" coverage currently works for children in Medicaid managed care plans shows that such coverage can be ineffective and that children in managed care often go without some needed care as a result.[216]

The final vote adopting the controversial measure was 216-214.

Even if coverage were ensured and generous, it would not be enough. Children in foster care do not have the support of their own parents to make sure that they practice good health habits, are seen regularly by health professionals, and follow—or are assisted in following—all regimens for prevention, care, treatment, and rehabilitation. At the same time, children in foster care may have more challenging health needs than other children. As the then-General Accounting Office

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[††] Established by the U.S. Secretary of Health and Human Services in May 2005 and charged to file two reports: the first on saving $10 billion in federal Medicaid expenditures and the second on longer-term changes to ensure sustainability of Medicaid.

(GAO)* advised Congress, "[r]esponsibility for providing care and services to foster children is shared by federal, state, and county governments, with HHS [U.S. Department of Health and Human Services] having responsibility for oversight of federal foster care programs."[217] States in turn have oversight of local implementation. States and localities establish policies and regulations. Thus, while federal law requires that "the case file contain a plan for appropriate care and services," these are "as determined by state and local foster care policies," the GAO went on to say.[218] Major responsibility, then, for deciding how appropriate care and services will be provided to foster children and youth—and assuring that they are provided—rests with states and localities. In studying the health care of very young foster children in three states in the mid-1990s, the GAO found that "[d]espite state and county foster care regulations, comprehensive routine health care for young foster children may not be ensured."[219] The GAO observed, "[l]ocal foster care agencies continue to grapple with designing programs to meet the health-related service needs of children."[220]

State policy, then, is central to achieving the goal of good health care for minority males in foster care. California has adopted a model worthy of attention. Four years after the GAO spoke to the issue, California created the Health Care Program for Children in Foster Care in 1999. To understand this model it is necessary to first look at the standard practice for monitoring how foster children and youth are doing. The standard practice is visits by caseworkers, with 43 states' requiring monthly visitation and the others' having standards that range from weekly to quarterly.[221] Despite large technology investments by federal and state governments, the Associated Press reported that more than half the states could not "produce computer-based reports detailing how often such visits occurred in fiscal 2003, according to a new report by the inspector general for the Department of Health and Human Services." Consider states where monthly visitation is required. Five of the 10 such states that were able to produce reports had visitation rates of less than 50 percent; in the other five the rates were 75 percent or less. Two of the 10 are jurisdictions of interest to this paper: Washington, D.C., with a 43 percent visitation rate, and Texas, with a 75 percent visitation rate. When even the frequency of visitation is not sufficient, how can health care needs be given adequate attention?

California's model aims to give these needs adequate attention by adding intensive nursing case management by public health nurses in local health departments to the services of the caseworkers in child welfare departments. The nurses are responsible for assessing health status, establishing a care plan, reviewing and maintaining medical records, monitoring compliance with the mandate for regularly scheduled physical exams, coordinating implementation of the plan (including entry to specialist care) with foster parents and caseworkers and educating them about how to meet the young person's needs, and serving as an ongoing resource to respond to questions and concerns.[222]

Federal law governing foster care supported with federal funds requires periodic administrative or court reviews.[223] Judges can make a difference in foster care practice. The story in the accompanying text box ("Foster Care and Judicial Checklists") shows that this was one result of the publication of a checklist of questions judges should ask about the education of the children and youth whose cases they are reviewing. Advocates for young minority males should ask whether similar changes could be wrought by a checklist for judges of questions to ask about health and health care. Could language in a report comparable to that in the text box someday read, "Drafters of the reports have certainly taken note that *health care* has become a priority for the court"?

Foster Care and Judicial Checklists[224]

Judges field-testing the Checklist reported that use of the Checklist from the bench resulted in a change in practice. Once the Checklist had been used repetitively and stakeholders (e.g., caseworkers, attorneys, Guardians *ad litem*) realized that questions with respect to the child's education were going to be asked from the bench, they began to regularly include educational information in their reports to the court in anticipation of those questions being asked. "When I first started asking about educational issues, they [stakeholders] would look at me like 'Well, what do you care? That's not important for you to know.' And now, the whole culture has changed," shared a judge. That judge went on to explain that now, educational information can be found within the first few sentences of a report to the court and that "drafters of the reports have certainly taken note that education has become a priority for the court."

Asking The Right Questions: A Judicial Checklist To Ensure That the Educational Needs of Children and Youth in Foster Care Are Being Addressed publishes both the checklist and assessment of its impact, including the results of focus groups in which *youth had the opportunity to guide the judges*. In this publication the National Council of Juvenile and Family Court Judges reports that one focus group participant said, "Make sure I am in Special Ed. for a reason…other than just because I am in foster care. Not all of us are behind or slow–and if we are, try offering us tutoring rather than putting us in special classes."[225] What would minority males in foster care say, in comparable circumstances, about their primary health, oral health, and mental health care? Judges who review foster care cases should ask the National Council to produce a checklist and guide for the questions they should ask about health care.

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* Now the Government Accountability Office.

An evaluation should then be done of the impact of use of the checklist on judicial practice, agency response, and foster youth's satisfaction.

Ensuring that youth who have aged out of foster care have coverage for and access to the health and mental health services that will meet their needs

Young adults' access to health care coverage is problematic in general. For former foster youth the chances for securing coverage through routes available to some other young people —that is, attachment to family, workplace or college—are much lower at the same time that the chances of not being healthy are higher. The actual availability of public coverage depends on where the young person lives, that is, on choices made by policymakers for that jurisdiction. In this paper, we have seen several opportunities for choices that could be helpful to youth who have aged out of foster care. For example, HIFA waivers are available to states to extend Medicaid coverage to selected populations. Advocates see these as offering promise for mentally ill youth, which could be a state choice especially relevant to some former foster youth. The other coverage options for the uninsured that have been explored in this paper are generally aimed at the working-age adult population, the population to which the former foster youth now belong. But the financing and design of any given option might not afford such youth adequate help with the most serious problems they may have, such as mental health disorders.

We saw that in San Francisco a generous coverage option has been implemented specifically for young adults, including former foster youth (who lose their full MediCal benefits at age 21). The Health Insurance for Young Adults project of the Adolescent Health Working Group in San Francisco has advocated for exempting former foster youth from certain restrictions on their eligibility for the city and county's Healthy Young Adults program. One policy goal has been to enable former foster youth who aged out before the program was created to join it while they are still within the program's age limits.[226]

The biggest opportunity for establishing coverage for former foster youth is the *Medicaid option in the Chafee Independence Program.* First enacted in 1999 and formally known as the Independent Living Initiative, this program is a capped federal entitlement of allotments to states (based on their numbers of children in foster care) which they must match at 20 percent. Besides serving youth who are likely to remain in foster care, a state must use part of its allotment for services and assistance to former foster youth ages 18-21. The Judge David L. Bazelon Center for Mental Health Law describes the aid to former foster youth in the following way: "The program also gives states the option of allowing youth who have left foster care on or after their 18th birthday to remain eligible for Medicaid up to age 21 and to use up to 30 percent of their program funds for room and board for these former foster children."[227] But, to date, the Chafee Medicaid option has been exercised by only eleven states.[228] The Bazelon Center sees this as a serious limitation because continued Medicaid eligibility can be extremely helpful for some of the most vulnerable youth aging out of foster care, those with serious mental health conditions. Eligibility "allows these youth to access important treatment and rehabilitation services (e.g., social skills and communications-skills training) that can aid them in independent living."[229]

But *Protecting Children*, mentioned earlier, sees the Chafee option threatened and argues that, rather than diminishing the chances that states will exercise the option, Congress should mandate that they extend eligibility for former foster youth up to the age of 21 and, further, create an optional extension beyond that in certain circumstances for former foster youth up to the age of 26:

> Significant spending reductions in the Medicaid program will certainly diminish the likelihood that this option will reach adolescents in additional states, and may imperil the availability of this option in the states already using it. Recent evidence from the Casey Family Programs' Northwest Alumni Study—which found that the majority of adult graduates from foster care had at least one mental health problem, while one in four had post-traumatic stress disorder, would suggest that the Congress consider changing this option to a requirement that coverage for adolescents departing foster care be mandated, in order to ensure appropriate time and resources to address their heightened health needs and to continue their treatment plans. In addition, just as many parents can continue dependent coverage up to the age of 26 for adult children who continue in education and training, states should have a similar option to extend coverage for young adults with an extensive history of foster care residence, who elect to continue their own education and training.[230]

States have flexibility to use their funding for a range of services. These include financial services, housing, education, case management, counseling, employment, and life-skills training. Including the support of mentors in life-skills training would help provide nurturing relationships that protect health, support mental stability, and help young people have the resiliency to avoid risky behaviors. It would be desirable to incorporate mentoring services for minority males into the transitional independent living care plan that federal law requires be developed for each youth in foster care supported under Title IV-E who is 16 or over. Services that will prepare the young person for the transition from foster care to independent living are to be covered by the plan.[231] The range of Chafee services is important for boosting the chances of young minority males who have been denied so many supports. The fact that the entitlement is capped so that states are not funded to serve all eligible children is, therefore, another important policy issue.

Recommendations for Action

State Health Policy for the Criminal and Juvenile Justice Systems

- Policymakers in each state should institute, finance, and monitor implementation of a comprehensive statewide investment strategy and initiative for reforming correctional health care—including care of juveniles in detention and commitment facilities—and post-confinement health care. The initiative should include the following:

    ➢ Accurate profiling of the health status and unmet needs of incarcerated adults and juveniles; the health and financial effects (including the spread of infectious disease) that failure to meet their needs have on inmates, former inmates, and the communities they re-enter; whether facilities comply with national guidelines for voluntary accreditation of correctional health care; and quantitative targets for improvements in care and outcomes in correctional facilities.

    ➢ Provision of post-confinement health care (including Medicaid or other coverage for adults, men's clinics, and uninterrupted access to medications prescribed in prison, jail or juvenile facilities) for adult and juvenile ex-offenders.

    ➢ Adoption of new budget architecture that facilitates the financing of correctional health care and post-confinement health care and support services, based on savings in law enforcement, corrections, and other relevant governmental functions derived from reduced recidivism.

- Policymakers in each state should establish a *hierarchy of preferences* for addressing unlawful, anti-social behaviors that arise from mental health and substance abuse disorders. At the start-up of this shift in public policy and spending priorities, increased funding for prevention, early intervention, and treatment may need to come from *projected* savings from reductions in crime, recidivism, and incarceration.

    ➢ Top preference: Prevention of disorders and, thereby, anti-social behaviors that arise from them through health promotion, screening, and early intervention.

    ➢ Second preference: To the maximum extent possible, without compromising public safety, provision of community-based treatment for disorders that have manifested in anti-social behaviors, without confinement, for adults charged with crimes and juveniles charged with offenses—through pretrial diversion, therapeutic sentencing, and special mental health and drug courts.

    ➢ Third preference: Provision to *all* incarcerated adults and detained or committed juveniles who have mental health and/or substance abuse disorders of clinically appropriate treatment, including model intensive drug treatment for adults.

    ➢ Fourth preference: For all adults and juveniles for whom incarceration was not prevented,[†] provision, upon release, of post-confinement fully-funded, comprehensive re-entry services that transform the post-confinement period into a period of secondary prevention and rehabilitation by ensuring health and promoting responsible behavior, family reunification, and economic productivity. (A model of re-entry services from the Centerforce, a re-entry services provider in California, can be seen in the text box.[232]) Features of the fourth preference include the following:

        o Emphasis on those diagnosed with health conditions such as mental health disorders, substance abuse disorders, and HIV/AIDS.

        o Removal of post-incarceration punishments (e.g., denial of right to vote, denial of access to housing, educational, and other benefits) that are barriers to establishing healthy, stable, and economically and socially productive lives and, further, are inconsistent with the proposed federal Second Chance Act of 2005: Community Safety through Recidivism Prevention introduced in April 2005 with bipartisan sponsorship.[233]

        o Special attention to and interventions to address the higher mortality rates that research shows are experienced by young people who have been involved with the juvenile justice system.

- In order to put the hierarchy of preferences into practice, implementation of the initiative should include the following steps:

[†] This preference relates to all individuals and is not limited to those whose unlawful conduct arose from mental health or substance abuse disorders.

Critical Re-Entry Services
Recommended by Centerforce

- 6 months or more of post-release case management [especially for persons at risk of contracting or spreading HIV].
- 6 months to 2 years of transitional housing beginning with the first night after release.
- "A comprehensive and progressive plan for transition from prison to the community, including attention to resources to support the plan, links between individuals and providers on the outside that can be made before release, and strategies for moving people in measured steps toward self-sufficiency."
- Job placement with salary support.
- Programs to build life skills, including managing anger.
- Family services, including reunification.

Screening and Assessment Guidelines From the National Center for Mental Health[234]

Screening should be performed for all youth at the earliest point of contact with the juvenile justice system. All youth should be screened to identify the possibility of mental health and substance use disorders. The screening should be brief and should be used to identify youth who require further evaluation and assessment. Although screening is most critical at a youth's earliest point of contact with the system, it should also be used to monitor mental health status at all stages of involvement with the system, particularly at transitions from one setting to another (e.g., from detention to secure corrections).

Assessments should be performed for youth who require further evaluation. More detailed assessments should be performed for youth whose initial screening indicates a need for further examination of psychosocial needs and problems. Although often more expensive than screening, assessment can yield more detailed diagnostic information about a youth's mental health and substance use status and can form the basis of treatment recommendations.

➢ Regarding mental health courts: States and localities should establish mental health courts for juvenile and adult offenders. The number and distribution of the courts should be sufficient to ensure that all offenders with serious mental health conditions have access to a mental health court. Each state legislature should hold hearings on mental health courts and set the direction for establishing them statewide. Testimony taken should cover, *inter alia*, the number of juvenile and adult offenders in the state who would likely benefit from access to mental health courts and the experience with establishing a court without incurring extra start-up costs. The Santa Clara County Juvenile Mental Health Court should be examined as a model.

➢ Regarding mental health disorders in juveniles: States and localities should adopt the best practices recommended by the Office of Juvenile Justice and Delinquency Prevention for universal screening with indicated follow-up assessment of juveniles for mental health disorders (see text box).

➢ Regarding intensive drug treatment for adult drug offenders: Intensive programs should combine assessment for substance abuse and mental health problems and co-morbidities; drug and alcohol counseling; mental health therapy sessions; education; job training; and life skills training. Inmates should participate in program activities for at least 50 hours a week, following the model of the Sheridan Correctional Facility in Illinois. Services should be provided in partnership with outside organizations. To the greatest extent possible, the methods for organizing and delivering services should begin to establish inmates' connection to aftercare in the communities to which they will return upon release. To ensure post-confinement follow-up to the treatment, state policy and financing should support communities in providing pre-release and recently released prisoners with training, jobs, substance abuse and mental health treatment, positive social supports, and other services.

State Health Policy for the Foster Care System

- Local, state, and federal financing, policy, and programs must ensure that children in foster care will receive early and periodic assessment of physical, mental, and oral health; diagnosis; care planning; treatment; and visitation to monitor and support health and health care. To strengthen this assurance:

  ➢ Foster care caseworkers should be properly trained to and regularly monitor health status and should be backed up by intensive public health nursing services.

  ➢ Court reviews required for foster care cases should place special emphasis on health care needs, especially those of minority males. Model guidance should be developed through the National Council of Juvenile and Family Court Judges.

➢ State legislative committees and caucuses should hold hearings on the health and health care of children and youth in foster care and hold state and local agencies accountable for solving identified problems. Youth in foster care, advocates, and state and national experts should testify as well as agency personnel.

➢ State policymakers and advocates for youth, especially minority male youth, should ask Congress to follow the recommendations of the Casey Family Programs on Medicaid (see text box). State policymakers should make these recommendations the positions of the National Governors' Association and the National Conference of State Legislatures.

Recommendations from
Protecting Children
(Casey Family Programs)[235]

- Preserve – Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits. If EPSDT is compromised, it could eliminate many prevention, treatment, and health maintenance options for children in foster care, especially those who are the sickest and most in need of services.

- Protect – the shared mission of Medicaid and child welfare services by adequately funding case management and rehabilitative services.

- Reject – cost-sharing proposals affecting children in foster care.

- Chafee Independence Program services should be provided to all youth who are likely to remain in foster care and to all former foster youth and include mentoring by minority males.

  ➢ State agencies should partner with community-based organizations to make this mentoring available.

  ➢ All states should exercise the Chafee Medicaid option for former foster youth up to the age of 21.

  ➢ State policymakers and advocates for youth, especially minority male youth, should ask Congress to lift the cap on the entitlement in the statutory authorization for this program, to make the Chafee option into a mandate, and, further, to create an optional exten sion beyond age 21 in certain circumstances for former foster youth up to the age of 26. (The circumstances should be that an individual was in foster care for a long time and, in adulthood, has chosen to pursue education and training.) State policymakers should make these proposals the positions of the National Governors' Association and the National Conference of State Legislatures.

APPENDIX

Reproduced from S. Silow-Carroll, S. E. Anthony, P. A. Seltman, and J. A. Meyer, *Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity* (Battle Creek, MI: W.K. Kellogg Foundation, 2001), pp. 36-40.

Table 3: Community-Based Programs to Improve Access for Uninsured Individuals*

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Alameda County, California	**County Medically Indigent Services Plan**	Alameda County Health Service Agency administers the program using a limited provider network for those with a medical need. The agency has exclusive contracts with Alameda County Medical Center and a network of CBOs. This is not an insurance program.	Target population is 120,000 county residents in need of medical attention with incomes below 200% of FPL and who are ineligible for Medi-Cal or any other health insurance. 51,686 patients served between July 1, 1998, and June 30, 1999.	Covers inpatient, outpatient, and specialty care, prescription drugs, and lab services.	The $60 million annual budget is financed through the county general fund, an increase in state sales tax, and an earmarked portion of state vehicle license fees. No cost-sharing for individuals with incomes below 100% of FPL. Sliding scale fee schedule for individuals with incomes between 100-200% of FPL.
Birmingham, Alabama	**Community Care Plan**	Jefferson County Health System administers the managed care plan using four primary care clinics and four network hospitals for inpatient care.	Target population is 250,000 uninsured county residents. 3,000 individuals enrolled in 1999.	Covers inpatient, outpatient, specialty care, prescription drugs, and lab services. Dental care is limited to oral surgery.	One of the network hospitals receives $37.5 million annually from the county for indigent care. The county also has a one-cent sales tax that finances indigent care. Program also receives Foundation grant money and $150,000 in annual sliding scale premiums (based on income) and co-payments at the four clinics.
Boston, Massachusetts	**Boston HealthNet (Pilot) Plan**	Boston Medical Center administers the program using its own facilities and 14 affiliated CHCs. The program does not have a formal managed care structure, but it is an insurance plan.	Target population is roughly 100,000 individuals in the Boston area who meet the residential and income guidelines of the state's uncompensated care pool. Eligible for full free care if family income is under 200% of FPL, subsidized care if between 200-400% of FPL. 68,565 individuals enrolled in May 2000.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, dental care, mental health and substance abuse services, and case management for the homeless.	Amount to cover receipt of care drawn from state uncompensated care pool; amount varies according to demand for services. Annual budget in 1999 was $94 million. Individuals with incomes between 200-400% of FPL pay based on a sliding scale fee schedule.
Buncombe County, North Carolina	**Buncombe County Medical Society Project Access**	Buncombe County Medical Society administers the program under a contract with Buncombe County. Mountain Health Care processes claims and provides data on physician services. The program relies on 500 volunteer physicians (85% of county physicians) to provide services. All county pharmacies participate, as well as two hospitals. This is not an insurance program.	Target population is 15,000 uninsured county residents with incomes below 200% of FPL with a need for medical attention. Roughly 13,000 patients a year receive care.	Covers inpatient, outpatient, specialty care, prescription drugs, and lab services.	Predominantly financed through medical service contributions, estimated to be $4.8 million in FY 1999: 60% from physicians, 40% from hospitals. Also financed through the county, which contributed $250,000 in FY 1999 and $350,000 in FY 2000. Most of these funds are used to pay for prescription drugs. The only patient cost-sharing is $4 per prescription.

***** In this table, we indicate whether each program covers the following services: inpatient, outpatient, specialty care, prescription drugs, lab services, dental care, mental health and substance abuse services, and case management. Some programs also cover additional services, including (but not limited to) emergency room services, ambulance services, transportation services, and vision care. For more detailed information on these or other services, see the table's sources cited below.***

Table 3: Community-Based Programs to Improve Access for Uninsured Individuals (cont.)

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Contra Costa, California	**Contra Costa Health Plan's Basic Adult Care (BAC)**	County-run HMO, Contra Costa Health Plan, administers BAC using a limited provider network of five county-operated health centers (outpatient) and one medical center (inpatient). Referrals for specialty care by primary care provider are permitted to an additional network of community providers. This is not an insurance plan.	Target population is county residents ages 19-64 ineligible for Medi-Cal or any other health insurance. Eligible only if there is a medical need, for sixmonth enrollment period. Individuals eligible up to $2,061 in monthly income; married couples up to $2,766. 4,000 patients enrolled in any given month.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, mental health services, and case management.	The $29 million program is financed with $19 million from the state and $9.5 million from the county (1999) Funding sources include county general fund, an increase in state sales tax, an earmarked portion of state vehicle license fees, tobacco funds, and some federal DSH money. There are sliding scale premiums based on income, although 88% of enrollees pay no premium.
Denver, Colorado	**CU Care**	Denver's University Hospital, University Health Sciences Center, and Kaiser Permanente of Colorado administered the managed care demonstration project from 1995-1998. Patients were treated at a primary care clinic (outpatient) and University Hospital (inpatient). Program's primary care clinic now continues to operate without a formal managed care component.	Target population was all uninsured Colorado residents who sought care at University Hospital with incomes under 185% of FPL. At its peak, the program had 12,000 enrollees. When funding was cut by 50% in final year, clinic limited care to patients referred by the emergency room.	Covered inpatient, outpatient, specialty care, prescription drugs, lab services, mental health services, and case management.	Funding was reduced by 50% in final year of operation. State uncompensated care block grant covered 30% of care costs, with balance financed through in-kind contributions from University Hospital, University Health Sciences Center, and Kaiser Permanente. Sliding scale co-payments, based on income, for outpatient and inpatient services and prescription drugs.
Hillsborough County, Florida	**Hillsborough County HealthCare Plan for the Medically Indigent**	County's Department of Health and Social Services administers the managed care plan using preferred provider networks consisting of hospitals, primary care physicians, and specialty physicians.	Target population is 28,000 county residents with incomes up to 100% of FPL who have no other health insurance coverage. Also eligible if medical expenses reduce an individual's income to 100% of FPL. 15,469 enrollees in January 2000.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, mental health services, dental care, and case management.	Financed through a $0.25 county sales tax and interest from a related trust fund. Enrollees with incomes up to 100% of FPL have co-payments for dental care only. Co-payments for other enrollees are on a sliding scale based on income.
Jacksonville, Florida	**WE CARE Jacksonville, Inc.**	A nurse employed by the city administers the program on behalf of WE CARE, a nonprofit corporation. The nurse coordinates referrals from volunteer physicians and 10 primary care clinics to specialty and inpatient hospital care. All area hospitals participate. This is not an insurance program.	Target population is 148,000 uninsured county residents. Individuals with incomes up to 100% of FPL are referred to the University Medical Center for care, as it receives funds from the city to care for the poor. Individuals with incomes between 100-150% of FPL can obtain referrals for specialty care. Program does not estimate how many individuals receive care.	There is no formal benefits package since available services depend on physician and hospital donations.	Financed primarily through donations of medical supplies and approximately 9,000 hours of physician time valued at $1.9 million. The city covers $70,000 in administrative costs. An annual physician talent show also raises $15,000 to $20,000. There is no patient costsharing.
Los Angeles, California	**Public-Private Partnerships**	County's Department of Health Services administers the program using 150 community clinics, of which 12 provide about half of all services. Most inpatient care provided at county facilities. This is not an insurance plan.	Target population is county residents without health insurance with incomes at or below 133% of FPL. Enrollment not provided by program.	Covers inpatient, outpatient, specialty care, and prescription drugs. (Services vary by clinic.)	The county spent roughly $42 million on the program in 1999, predominantly financed through the county's Medicaid 1115 waiver. The county also contributes money from general revenues. Cost-sharing is not required and varies from clinic to clinic.

Table 3: Community-Based Programs to Improve Access for Uninsured Individuals (cont.)

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Marion County, Indiana	**Wishard Advantage**	The County's Health and Hospital Corporation administers the managed care plan using one public hospital and seven CHCs (managed by Indiana University Medical Group). Does not use "gatekeeper" model but does require referrals for most specialty care.	Target population is 40,000 adult county residents with incomes up to 200% of FPL not eligible for any other type of assistance program. 22,000 enrollees in June 2000.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, and mental health services.	Roughly $76 million budget financed through $20 million in federal DSH matching funds and $56 million in city and county property taxes. No cost-sharing for enrollees up to 150% of FPL. Enrollees between 150-200% of FPL are charged for services on a sliding scale based on income.
Milwaukee County, Wisconsin	**General Assistance Medical Program**	The county's Department of Health administers this program using a third-party administrator for billing. Program uses 14 CHCs to provide primary care (acting as gatekeepers) and 22 clinics overall. Each clinic must affiliate with at least one hospital and pharmacy. This is not an insurance plan.	Target population is 130,000 county residents who are not eligible for any other health insurance coverage, earn a gross income of no more than $800 per month (individual), and have a medical need. Roughly 18,000 enrollees annually.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, mental health and substance abuse services, dental care, and case management.	Annual budget of $38 million financed through a county property tax levy that was dedicated to a now-closed county hospital (55% of budget) and a state block grant that includes federal DSH money (45% of budget). There is no patient costsharing.
St. Louis, Missouri	**Saint Louis ConnectCare Health System**	A nonprofit public-private partnership, headed by 17-member board of directors, administers the managed care plan using a third-party administrator for daily management of operations. The program operates a network of clinics and partners with four hospital systems for specialty and inpatient care.	Target population is all uninsured residents of St. Louis city and county with incomes up to 100% of FPL (free care), or above 100% of FPL on a sliding fee scale basis. Serves 30,000 annually.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, and dental care.	Annual budget of $38 million financed through the state ($21-26 million, including $8 million in federal DSH money), the city ($5 million), the county ($2 million), and operating revenues. Patients with incomes above 100% of FPL pay on a sliding fee scale basis.
San Antonio, Texas	**Carelink**	The University Health System (UHS) administers this program, which subsidizes the cost of medical care. The program uses a "closed" system, relying on UHS's hospital and its six ambulatory care centers. The program's extended network also includes five FQHCs and one private physician. This is not an insurance program.	Target population is 250,000-300,000 county residents who are low-income and uninsured, but program is available to all county residents regardless of income or insurance status (e.g., Medicare enrollees who lack drug coverage). The programalso provides a 90-day membership for individuals who become unemployed. 62,621 enrollees in October 1999.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, and case management.	Program financed through a county hospital district property tax ($0.25 per $100 property valuation). In 1999, some federal DSH money also helped fund the program. There is no cost-sharing for patients with incomes below 75% of FPL. Above 75% of FPL, monthly payments vary. For prescriptions, there are no co-pays for those with incomes below 75% of FPL; $2 co-pays for those with incomes 75-150% of FPL; and $4 co-pays for those with incomes above 150% of FPL.
Shelby County, Tennessee	**Shelby County Health Care Network**	Under contract with the county, the Shelby County Health Care Corporation administers this program, which uses 10 primary care clinics and one urgent care clinic to deliver services. This is not an insurance program.	Target population is all residents of the county, with the goal of developing a more diverse payer mix. There is no enrollment process per se.	Covers outpatient, specialty care, prescription drugs, dental care, and case management.	Program financed from the county's general revenue, capped at $4.1 million annually. No information provided about cost-sharing.

Table 3: Community-Based Programs to Improve Access for Uninsured Individuals (cont.)

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Wayne County, Michigan	**PlusCare**	The Patient Care Management System, created by the county, administers this program, which contracts with three health plans and one dental plan.	Target population is 50,000-55,000 county residents ages 21-64 who are not eligible for any other health insurance coverage and have monthly household income of no more than $250 (excluding child support and Social Security payments). Enrollment is roughly 31,000-35,000.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services. Dental care is limited to dentures and extractions. Does NOT cover mental health and substance abuse services, but plans are required to establish a system of referrals for these services.	The $44 million annual budget is funded by a hospital indigent care pool financed by state Medicaid, federal Medicaid matching, and county general funds. There is no patient costsharing for most health care services. There is a $0.50 copay for prescription drugs and a $3.00 co-pay for hearing aids.

Sources: Andrulis, D. and Gusmano, M. Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? (The New York Academy of Medicine, August 2000); Silow-Carroll, S., Anthony S., and Meyer J., State and Local Initiatives to Enhance Health Coverage for the Working Uninsured (Economic and Social Research Institute, Washington, D.C., October 2000).

Table 4: Community-Based Programs to Improve Access for Small Businesses and Uninsured Employers†

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Denver, Colorado	**Denver Health Medical Plan— Small Business Premium Subsidy Program**	Denver Health, an independent governmental authority that runs Denver's public health care system, administers this premium subsidy program for employers with 2-50 employees. The program offers three different health plans to the small businesses: a basic plan, a standard plan, and a premier plan.	Target population is employers and employees of small, low-income businesses without health insurance coverage. Firms must have 2-50 workers; must not have offered coverage in prior 90 days; and must have net income of $50,000 or less during the previous year. As of December 2000, 20 businesses were receiving the subsidy.	Covers inpatient, outpatient, lab services, and mental health and substance abuse services.	The program is financed through a 5-year, $5 million grant from The Colorado Trust and the W.K. Kellogg Foundation. This amount pays for a subsidy worth 20-50% of the total premium, determined on a sliding scale based on the firm's net income during the previous year. The employer and employee must pay the balance. The subsidy is available in years one, two, four, and five, with no subsidy in year three to determine the extent of retention of coverage without assistance.
Wayne County, Michigan	**HealthChoice**	The Patient Care Management System (PCMS), created by the county, administers this subsidized managed care program for businesses with three or more employees. PCMS contracts with a third-party administrator for collections and billings. The program contracts with five different health care networks from which enrollees may choose. Enrollees are assigned to primary care providers, who function as gatekeepers.	Target population is 9,000 county businesses with three or more employees. 50% or more of the employees must average an hourly wage of $10 or less; and employees must work at least 20 hours a week for an anticipated period of at least five months and be ineligible for other health insurance coverage.In June 2000, there were 19,019 employees and 1,977 small businesses enrolled.	Basic coverage includes inpatient, outpatient, specialty care, prescription drugs, and lab services. For additional premium charges, employers can receive optional benefits, including unlimited inpatient hospital days, mental health and substance abuse services, and dental care.	The $16.8 million annual budget is partially financed through premiums for health coverage. Premium costs are divided in thirds among employer, employee, and the program. The program obtains its funds from a hospital indigent care pool financed by state Medicaid, federal Medicaid matching, and county general funds. $5 copays are required for prescription drugs and physician visits. There are separate surcharges for dental benefits.

†In this table, we indicate whether each program covers the following services: inpatient, outpatient, specialty care, prescription drugs, lab services, dental care, mental health and substance abuse services, and case management. Some programs also cover additional services, including (but not limited to) emergency room services, ambulance services, transportation services, and vision care. For more detailed information on these or other services, see the table's sources cited below.

Table 4: Community-Based Programs to Improve Access for Small Businesses and Uninsured Employers (cont.)

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
San Diego, California	**FOCUS (Financially Obtainable Coverage for Uninsured San Diegans), Sharp Health Plan**	Sharp Health Plan administers the premium assistance program for small employers and low- to moderate-income employees. The program is a partnership between Sharp Health Plan and Alliance Healthcare Foundation in which Sharp Health Plan offers insurance coverage and the foundation subsidizes premiums. The insurance is a "no frills," standard commercial plan.	Target population is more than 150 small businesses with 50 or fewer employees, and up to 2,000 full-time employees with incomes up to 300% of FPL. To be eligible, small businesses cannot have provided coverage in the past year, and employees cannot have been insured in the past year. As of June 2000, 1,699 employees and 216 businesses were participating.	Covers inpatient, outpatient, and prescription drugs. Mental health and substance abuse services are limited to outpatient services.	Premiums are subsidized through a $1.2 million grant from Alliance Health Foundation and a portion of a $400,000 grant from The California Endowment. Employer contributions to premiums are fixed, and employees pay according to a sliding scale based on income and family size. There are $5 co-pays for physician office visits and $5 generic/$15 brand co-pays for prescription drugs.
Muskegon County, Michigan	**Access Health**	The nonprofit Muskegon Community Health Project (MCHP) administers this program, which targets uninsured individuals who work for small to medium-sized businesses. The program is not an insurance plan. It has a network of providers with which it contracts directly. MCHP is a Comprehensive Community Health Models partnership of the W.K. Kellogg Foundation.	Target population is up to 3,000 full- or part-time (not seasonal or temporary) working, uninsured individuals in small to medium-sized businesses in Muskegon County. To be eligible, businesses can have up to 150 full- or part-time employees; must not have provided insurance for the last 12 months; and must have a maximum median wage of eligible employees of $10 per hour or less. As of June 2000, 155 small to medium-sized businesses were participating.	Covers inpatient, outpatient, specialty care, prescription drugs, and lab services.	The $4 million annual budget is financed through a shared buy-in among employer (30%), employee (30%) and community match (40%). Community match is comprises of federal DSH, local government, community, and foundation funds. Co-payments are required for most services (e.g., $5 for primary care provider office visit and $20 for specialist visits).

Sources: Andrulis, D. and Gusmano, M. Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? (The New York Academy of Medicine, August 2000); Silow-Carroll, S., Anthony S., and Meyer J., State and Local Initiatives to Enhance Health Coverage for the Working Uninsured (Economic and Social Research Institute, Washington, DC, October 2000).

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ABOUT THE AUTHOR

Kay Randolph-Back is a consultant in health policy. From 1993 to 2003, she served as program analyst in health programming at the W. K. Kellogg Foundation. Previously, her career was in state government in Michigan where she was health consultant to the health and social services committee in the Senate, served the directors of three executive departments as special assistant in the areas of health and human services law and policy, actively developed legislative and executive proposals, and staffed two gubernatorial blue-ribbon commissions, one concerning Medicaid and health care cost containment, the other, welfare reform. She has also been senior policy analyst at the New York Academy of Medicine and public policy director for the statewide work of an anti-hunger coalition.

Ms. Randolph-Back's policy interests and experience encompass, *inter alia*, equity and access in health care for the underserved and uninsured, minority health disparities, the social determinants of health, quality assurance, consumer participation in governance of health care organizations, health occupations licensure and regulation, the gender gap in education and opportunity for young minority males, and food assistance and nutrition programs for low-income people. She is an experienced author and editor. Her written work includes numerous papers, reports, legislative proposals, and book chapters.

She earned a juris doctor degree from Georgetown University Law Center, a master's degree in English literature from the University of Pennsylvania, and a bachelor of arts degree from St. John's College, Annapolis.

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The mission of the Joint Center Health Policy Institute (HPI) is to ignite a "Fair Health" movement that gives people of color the inalienable right to equal opportunity for healthy lives. HPI's goal is to help communities of color identify short- and long-term policy objectives and related activities in key areas. The Joint Center for Political and Economic Studies is a national, nonprofit research and public policy institution. Founded in 1970 by black intellectuals and professionals to provide training and technical assistance to newly elected black officials, the Joint Center is recognized today as one of the nation's premier think tanks on a broad range of public policy issues of concern to African Americans and other communities of color.

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