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Mental Health Care in Juvenile Detention Facilities: A Review

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Juvenile detention facilities have come under increasing legal pressure to provide mental health services to detainees, and mental health clinicians may be asked to design and implement programs in detention facilities. However, there is little consensus on what types of services should be provided, and virtually no data on the effectiveness of such services in a detention setting. The objective of this article is to provide an overview of the existing literature on mental health services in juvenile detention and to make suggestions about future research needs. Specifically, it highlights the tension surrounding the provision of mental health care in juvenile detention, presents data on the prevalence of psychiatric problems in detention settings and what types of services are currently provided, and draws on the larger child and adolescent mental health literature to suggest what types of services might be most appropriate for juvenile detention settings. We conclude that, although there are some suggestions of promising interventions that may be appropriate, much more research, specifically in detention settings, is needed to determine their effectiveness.

J Am Acad Psychiatry Law 34:204–14, 2006

It has been recognized for some time that juveniles involved with the criminal justice system have high rates of substance abuse and psychiatric disorders. It has also been noted that the criminal justice system has been an important vehicle for accessing services for some youths.[1] However, in general, the system has not been seen as effective in addressing the service needs of youths in detention. Many detained juveniles in need of care do not receive services, and with both overcrowding and a large number of mentally ill youth in detention centers, episodes of injuries, suicides, and other adverse health effects are increasing.[2] Poor conditions of confinement in detention facilities have resulted in court cases and legal mandates for changes to the system. Many of these cases have served as the impetus for juvenile detention facilities to expand their mental health and substance abuse services for youths in their care.

This article is intended for mental health professionals who may be asked to deliver such psychiatric care in a juvenile detention setting. However, it may also be helpful for correctional staff, court support service personnel, judges, and policy makers concerned with the health of juveniles held in detention facilities. Our goal is to provide a review of current knowledge on mental health services in juvenile justice settings, in an effort to inform attempts at improving those services, and to assist clinicians in designing and implementing programs for detained youths.

First, we describe juvenile detention for those who may be unfamiliar with the setting. Second, we review the literature on the rates and types of psychiatric disorders a clinical provider can expect to encounter in this population. Third, we briefly discuss the political tensions that surround mental health services in detention settings. Fourth, we summarize what services are generally now provided in these settings. Finally, we review the literature on the effectiveness of services provided in the juvenile detention setting, examining a few strategies that have been found to be effective in this population, but

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largely drawing on the greater adolescent treatment literature to speculate on strategies that might be generalizable to detention settings specifically.

History and Philosophy of the Juvenile Court System

In the late 1800s several states began to adopt the practice of trying adolescents and children separately from adults.[3] These practices stemmed from social attitudes that recognized adolescents as developmentally different from adults and changed criminal court procedures so that juveniles, instead of being punished for crimes, could be guided through state intervention into more mature and healthful pathways to adulthood.[4] Where children needed to be detained for their own or society's greater good, such detention was provided in homelike, usually nonsecure, settings.[5] After World War II, an increase in the need for detaining minors, particularly in large urban centers, led to a construction boom in correctional centers.[6] Many of these facilities were termed reform schools, and provided education, discipline, and health services in an institutional setting. Concurrently, smaller secure facilities (detention facilities) were established to house juveniles before disposition decisions and adjudication.

By the late 1960s, owing to a lack of funding, many detention facilities offered only minimal educational and vocational services. Child advocates argued that juveniles were not getting adequate services[3] and were mainly housed in larger, more secure institutional settings that were too punitive and jail-like. Over the next three decades, the approach to detention swung widely from attempting to "treat" delinquency, to harsher sanctions for crimes. In the 1990s, the Department of Justice and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) attempted to balance these extremes with an approach that utilized the full protections of due process and employed diversion programs as much as possible, but also emphasized offender accountability and community safety.[7]

Pathways into Juvenile Detention

Today, juvenile facilities can be divided into two categories. The first type, detention centers, holds juveniles principally during the pre-adjudication phase of the case, or in rare cases while post-adjudicated juveniles are awaiting an alternate disposition such as placement in a residential program. The second type is correctional centers, where post-adjudication juveniles have been placed by court order as one of the options available to the court to deal with serious juvenile offenders. This article focuses only on detention facilities.

Young people may enter detention centers for several reasons. First, those who are perceived to be at high risk of committing new crimes are detained for the safety of the community. Second, certain charges, such as homicide or sexual assault, are serious enough to warrant automatic detention. Third, youths who might not make required court appearances are detained until the case can be adjudicated. Finally, many youths enter detention because there are perceived to be no suitable alternatives. That is, courts and other decision makers are concerned that there is no suitable adult to supervise, or a suitable environment into which to release the youth. In some cases, parents can request the court to place their child in detention because they are unable to control their child's behavior.

These various pathways into detention are reflected in the array of charges assigned to juveniles in detention centers. In a 1999 census of juvenile detention facilities, the OJJDP assessed the prevalence of the most serious charge assigned to each detainee residing in the facility on a given day. Out of the 27,404 juveniles in a detention facility in the United States, 29 percent were charged with a violent crime, 26 percent with property crimes, and 9 percent with drug-related offenses.[8] An additional 37 percent were charged with public disorder, a technical violation (e.g., failure to appear), or a status offense. A status offense is a charge stemming from behavior that is illegal only because of the age of the offender (e.g., underage drinking, running away from home, truancy).

Sociodemographic Profile of Juveniles

The sociodemographic profile of adolescents placed into a detention facility does not reflect the general U.S. population. First, minorities are disproportionately detained: although only 34 percent of the general population is under age 17, minorities make up about 62 percent of juvenile court charges that result in detention, and this disparity is not fully explained by differences in rates of offending.[8] Differences are particularly evident at the detention decision point: given similar offenses, minority youths

are more likely to be detained and for longer periods than are whites. While the custody rate among whites is 204 per 100,000, among black youths it is 1,018 and among Hispanic youths 515 per 100,000. Minority lengths of detention are on average a week longer.[8,9]

Second, males are disproportionately represented among adolescents in juvenile detention facilities: in the 1999 detention census, only 17 percent were female.[8] However, there are some important distinctions between males and females in juvenile detention facilities. First, girls in detention were younger and more likely to be white.[8] There were also gender differences in offense patterns. Females were overrepresented among status offenders: despite being less than 20 percent of the total detained population, females made up 64 percent of runaways, 47 percent of truants, and 28 percent of curfew violators.[8,10]

Prevalence Rates of Psychiatric Disorder

There are only a few standardized studies of juveniles in detention facilities in which extensive assessments of psychiatric status were performed. However, we can make several conclusions from existing evidence. First, the most conservative estimates for rates of psychiatric disorders expected in detention would be those that mirror prevalence in the general population.[11] Roberts *et al.*,[12] in a review of several decades of research on psychiatric disorders in children, determined that prevalence rates for current psychiatric disorders were estimated to be 16.5 percent in adolescents. We can thus expect that at least 16 percent of the detention population will have a diagnosable psychiatric disorder.[12]

Recent studies, however, have indicated that the actual rates in detention are likely to be much higher. Although only a few studies have been conducted with rigorous methodology, a large enough sample size, and reliable and valid diagnostic instruments, they all have come to similar conclusions: as many as 65 percent of youths in the juvenile justice system have a diagnosable psychiatric or substance abuse disorder.[11,13–19]

The most recent study that assessed psychiatric disorders specifically among youths in detention using diagnostic psychiatric assessments was conducted in the Cook County juvenile detention center, one of the largest in the country.[15,19] Although limited to a single detention facility, the study used random sampling techniques and rigorous diagnostic assessment procedures to assess the prevalence of disorders. Teplin and colleagues[19] found that the six-month prevalence of any psychiatric or substance-use disorder was 66.3 percent in males and 73.8 percent in females. These estimates were not solely explained by behavioral disorders such as conduct disorder (CD): when CD was removed, the prevalence rates were 60.9 and 70.0 percent, respectively. The most highly prevalent disorders were substance-use disorder (47%–50%); CD (38%–41%); anxiety disorders (21%–31%) including high rates of post-traumatic stress disorder (PTSD) (11%–14%); and affective disorders (19%–28%). There were also significant differences in the rates of disorder not only by gender, but also by race and age.

These rates are substantially higher than estimates from community populations.[20] Even allowing for potential over-reporting of symptoms due to the stress of being in a detention environment, it remains that the study by Teplin and colleagues[19] indicates that the majority of juveniles in detention can be expected to suffer from a psychiatric and/or substance-abuse disorder.[11,20,21]

Another finding of the study by Teplin and associates[19] was the high rate of comorbidity across psychiatric diagnoses.[15] Fully 75 percent of respondents with one disorder met diagnostic criteria for two or more disorders.[15] Comorbidity poses a particularly difficult problem, since disorders may exacerbate each other and make treatment more difficult. However, more research is needed on the rates of comorbidity and their effects on treatment outcomes.[20]

Indications for Treatment

Detention centers serve to hold juveniles in custody while they await adjudication and disposition of their court cases. Although somewhat simplistic, this restraint has been approached in one of two ways: preventive detention or therapeutic detention.[22] The tensions that surround the provision of mental health services in detention centers in part stem from the tensions between these two philosophies. Preventive detention implies that the facility merely holds offenders in a secure setting because they may pose a danger to society, be a flight risk, or be unlikely to appear at required court hearings. Aside from basic mandated services such as education and management of acute health problems, the facility only serves to remove offenders from the community until the court can determine where they should be placed.

Therapeutic detention fulfills the same function, but adds an element of provision of supportive or therapeutic care, such as general support and counseling, more formal behavioral health care, or "treatment" of delinquency or violence. Critics of the therapeutic detention philosophy have posited three objections. First, the short length of stay limits chances for effective intervention, and in some cases may be detrimental if a clinical relationship is suddenly severed. Second, the availability of such services inside juvenile detention facilities, particularly when such services are limited in the community, introduces the possibility of inappropriate placement in detention as a way of accessing needed services.[1] Finally, the relative lack of effectiveness data on such therapeutic interventions inside juvenile detention settings raises concern about the appropriateness of providing such services.[22]

Litigation in response to poor conditions of confinement has resulted in several consent judgments and settlements that require juvenile detention facilities to provide mental health services under the rule that an acute mental health need, if not treated, constitutes deliberate indifference. For example, the plaintiffs in *Emily J. v. Weicker* (1997) alleged overcrowding and inadequate medical services, recreation, staffing, and programming. A corrective-action plan was ordered by the court and included, among other changes, mental health screening at admission and mechanisms for recommendations for further evaluation and treatment, if indicated.[23] Litigation by plaintiffs in New Jersey, Washington, New York, and Pennsylvania, among other states, has also advocated for improved mental health services.[24] In all these cases, systems were held responsible for failing to provide basic levels of several different types of services, including adequate health care to detainees with psychiatric disorders.

In addition to advocating for minimally required levels of care, proponents of therapeutic detention also argue that there are several advantages to instituting treatment programs in such settings beyond acute intervention: (1) it is a setting where a wide range of behavior control strategies are available, unlike many community settings such as foster homes or schools; (2) though lengths of stay are short, treatment begun in such settings may steer the momentum in a positive direction; (3) compared with large community programs such as those funded by child welfare agencies, the staff-to-child ratio can be smaller, allowing more personalized attention; and (4) as a community-based resource to court services, such facilities can promote continuity of care by providing links to other community social and mental health care services.[22]

Types of Mental Health Services

The National Commission on Correctional Health Care (NCCHC) has published standards of care (both health and mental health) for juvenile facilities, and the Council of Juvenile Correctional Administrators is developing and field testing updated standards for safety, health and mental health, programming, security, justice, and order within juvenile detention and correctional facilities.[25] Only a very small proportion of facilities are formally accredited as meeting these standards. Accreditation is not required, and facilities with limited resources are not likely to meet the standards or have the staff resources to achieve accreditation.

Despite the lack of widespread official accreditation, however, the NCCHC position paper on mental health services in correctional settings cites case law as establishing minimum requirements for such care: (1) every detainee should be screened quickly for potential psychiatric problems and current medication; (2) treatment plans should be developed by qualified mental health staff and appropriately documented, reviewed regularly, and communicated to detention staff; (3) current medication regimens should not be interrupted, if possible; (4) acute psychiatric symptoms should be treated appropriately, either within the facility under the supervision of a qualified clinician or in an alternate clinical setting such as a hospital; (5) psychotropic medication should be used in accordance with scientific evidence and professional standards to treat psychiatric symptoms, not merely to control behavior; (6) the facility should have appropriate suicide prevention measures in place; and (7) efforts should be made to provide links and referrals to mental health care in the community, as appropriate.

In the early 1990s, the OJJDP conducted a survey of juvenile justice facilities to assess "conditions of confinement," defined as the degree to which facilities met treatment standards.[26] The data presented herein are supplemented by additional data collected in 1998 on mental health services provided to youths in the juvenile justice system.[27]

Table 1 Screening and Assessment Rates in Juvenile Detention Facilities

Type of Assessment	Detainees Screened or Assessed (%)
General screening	
Emergency medical problems	97
Drug or alcohol use	91
Potential behavioral problems	62
History of mental health problems	73
History of mental health treatment	57
More extensive assessment	
Mental health problems	61
Drug use/abuse/dependence	78
Alcohol use/abuse/dependence	75

Mental Health Screening and Assessment

The OJJDP report recommended that an initial health screening be performed within one hour of admission to a detention facility[26,28] to assess physical and mental condition upon intake, including drug and alcohol use. Table 1 presents the percentage of detained youths who were receiving these screening services. As can be seen, rates of screening are generally higher for medical or substance-related problems than for mental health problems or treatment.[26]

In the 1998 CMHS study, 71 percent of juvenile detention centers reported providing screening services, defined as identifying youth at risk for mental health problems, identifying needs for care, and referring to needed services.[27] The OJJDP survey also examined what assessments (beyond simple screens) were conducted to assess the possibility of specific health problems. Again, assessments were more likely to be made for drug or alcohol use than for potential mental health problems. The range of assessments conducted was also variable, and in most cases facilities were not using standardized assessment instruments. In addition, over a third of juveniles in detention were assessed on these measures by staff who were not trained by a health professional, thus reducing the reliability of the collected data.[26]

In addition to an initial health screening, the OJJDP also recommended that facilities perform an in-depth health appraisal within seven days of admission,[26,28] including a mental health assessment, performed by a licensed mental health professional, particularly if the screening indicated potential psychiatric problems. Such an assessment could serve several purposes: (1) to inform treatment decisions inside the facility; (2) to perform risk management of potential problem behaviors; and (3) to assist with community referrals to care. However, in some jurisdictions such an assessment might also be used, in part or in full, to assist courts in making disposition decisions. The 1998 CMHS study reported that 56 percent of detention facilities provided a clinical evaluation or appraisal of treatment needs, beyond a simple screening.

Mental Health Services

The NCCHC standards recommend that all juvenile detention facilities provide mental health services by qualified professionals.[26,28] It is expected that such professionals will not only work directly with detainees, but will train other facility staff in how best to interact with detention residents. In the 1991 conditions of confinement survey, 87 percent of juveniles in detention were in a facility that had mental health professionals available. However, many detainees (49%) had access to these professionals less than daily, or only on an on-call basis.[26] By the time of the 1998 survey, 61 percent of facilities reported having the services of a psychiatrist available, and 70 percent reported having the services of another mental health professional available.[27]

Table 2 presents the percentage of juveniles in detention who had access to specific types of mental health and substance abuse care, as reported in the OJJDP survey. The definitions of these services were not standardized and thus vary widely across facilities. Therefore, it is difficult to determine, for example, the exact nature of substance-abuse treatment in these facilities (e.g., group versus individual, 12-step versus other models). Overall, it appears that the availability of specific behavioral health services in detention facilities is fairly low, with the exception of

Table 2 Mental Health and Substance Abuse Services in Juvenile Detention Facilities

Type of Services	Juveniles in Detention With Access to Services (%)
Informal counseling/support	77
Family counseling	41
Services specifically for sex offenders	21
Services specifically for violent offenders	22
Services for drug/alcohol dependency	47
Suicide risk reduction	46
Services specifically for arsonists	6
Other specialized services	4

general support services, but is most likely to be related to substance abuse and suicide risk reduction.

Psychotropic Medications

There are no published national data on the rates of use of psychotropic medications in detention facilities. However, two recent surveys inside juvenile facilities in Pennsylvania and Oregon indicate that the use of such medications is not uncommon. In Pennsylvania, detention center directors indicated that there were at least some juveniles in every facility who were taking psychotropic medication at the time of their admission, and at the smaller facilities the rate was as high as 40 to 50 percent.[29] In the 2002 Mental Health Gap Survey in Oregon, of the female incarcerated juvenile offenders with a diagnosed psychiatric disorder, 72 percent were receiving medication as part of the treatment regimen, compared with 54 percent of males with such diagnoses.[14] It should be noted that this study was conducted among juveniles in longer-term correctional facilities, not detention facilities, so the rates are likely to be higher than those that would be expected in a detention facility. However, taken together, these surveys suggest that a substantial proportion of those entering detention may already be taking or need psychotropic medication.

Potential Service Strategies in Detention Settings

The final section of this article reviews what is known about effectiveness of services delivered in detention settings. Owing to the short lengths of stay as well as other difficulties with performing research in these settings, there are virtually no controlled studies of interventions in detention. However, this section draws on intervention research performed in the community that may be effectively translated across settings. We chose these interventions based primarily on the possibility of their implementation in 30 days or less.

It should be noted that there are no widely accepted or published best practice standards of behavioral health care in juvenile detention settings. In fact, there is controversy over the findings in much of the literature regarding treatment strategies for children in general. For example, one review found strong methodologically sound evidence of successful treatment strategies for only four psychiatric, non-substance abuse disorders: depression, attention-deficit disorder, anxiety, and disruptive behavior disorders. There is additional concern that strategies found to be effective in controlled trials may be much less so in real-world environments.[30] However, an evidence base, though paltry, must begin somewhere, and we have culled what appear to be the most appropriate strategies based on the community literature and face validity. Future research will be tasked with rigorously evaluating such strategies in detention settings.

Screening and Assessment

In 2002, a national panel of experts was convened to respond to the lack of best practice standards for assessing mental health needs in the juvenile justice system.[31] They recommended five standards for mental health assessment in this population: (1) perform a valid and reliable mental health screen within 24 hours of admission; (2) perform a more extensive assessment by a mental health professional as soon as possible to determine service needs; (3) use multiple sources of information (e.g., medical records, family reports) to determine needs; (4) screen detainees before their release into the community; and (5) repeat screens on a regular basis while detainees are in custody, to identify emergent problems.[31]

There are several dozen scientifically sound survey instruments for use in screening for potential mental health problems or for assessing general mental health status, suicide risk, drug and alcohol use/abuse, and the risk of violence.[32] Many can be administered easily with little staff training, in some cases can be self administered, and in many cases have been used or tested in juvenile justice populations. The instrument most widely used for screening, and one that was developed specifically for this age group and population, is the Massachusetts Youth Screening Instrument-2 (MAYSI-2).[33]

The MAYSI is a 52-item true/false instrument that alerts staff to potential problems in seven areas: alcohol/drug use, anger/irritability, depression/anxiety, somatic complaints, suicidal ideation, thought disturbance, and traumatic experiences. Cutoff scores are set at a threshold where respondents require immediate clinical attention; however, the MAYSI is not meant to substitute for a more thorough psychiatric assessment. To date, over 200 detention facilities in 30 states routinely use the MAYSI to screen all incoming juveniles[33] and it has

been tested for reliability and validity in this population.[34–36]

The Consensus Conference noted that there are no instruments that collect data on all the elements of a potential risk assessment: symptoms, mental health service use, medication use, and family history of psychiatric illness. They encourage more research to develop instruments to collect accurate and reliable data on all of these domains.[31] Until such an instrument is available, facilities are encouraged to use only instruments that have been validated; are age, gender, and culture appropriate; and do not pose an undue burden on raters or respondents.[32]

Case Management

Case management is one intervention that has received some attention in the juvenile justice research literature. Case management refers to a system whereby a single provider coordinates a myriad of services, both within and across service systems. In the case of detention facilities, case managers conduct intake assessments and evaluations to identify individual needs, assist detainees and their families in securing mental and physical health treatment and social welfare services, monitor service utilization, and occasionally serve as a liaison between the families and the court. Such services can be crucial to detainees who have psychiatric and substance abuse problems. Although the case manager often provides little traditional clinical care, the coordination of services is deemed so crucial as to make case management a clinical service by itself.

Case management programs have been instituted in many adult correctional settings and outcomes data indicate that offenders enrolled in such programs have less drug use and recidivism and more employment after release to the community than offenders who did not receive case management.[37] One program that instituted case management for juvenile offenders with mental health needs showed that case managers were able to foster access to mental health services in the community, which reduced both hospital and detention center time.[38] There have been no published controlled studies of case management in juvenile detention settings. However, it has been fairly extensively studied in community samples of youths with mental health and substance abuse problems, showing clear benefits.[39] The primary challenge in detention is the speed with which case managers have to provide services, given the short length of stay.

Drug and Alcohol Treatment

Of all the behavioral health services provided in juvenile detention facilities, among the most common are drug and alcohol treatment. A recent comprehensive review and meta-analysis of adolescent substance abuse treatment in non-detention settings found only 53 treatment studies in the past 30 years, and only 21 were methodologically sound enough to warrant including in the analysis.[40] The authors were able only to conclude that treatment (in any form) was more effective than no treatment at reducing drug use in the following year.[40] No distinction was made across types of treatment programs.

Recently, a non-profit group called Drug Strategies convened a panel to review, synthesize, and make recommendations on substance abuse treatment for adolescents. Their report identified key elements of effective drug treatment programs in this age group[41] and surveyed 114 programs that were identified by the consensus panel, national organizations, or state mental health agencies as being exemplary in at least one of nine key areas. Of the 114 programs, 16 indicated that their standard treatment cycle lasted for 30 days or less, making them potential candidates for adoption in a detention center setting. When asked what types of therapy models were utilized, the majority indicated that they offered a combination of a 12-step approach (12 of 16) and/or cognitive behavioral therapy (10 of 16). It should be noted that only 4 of the 114 programs surveyed by Drug Strategies had any data on clinical outcomes and none of those four had short lengths of stay. Therefore, although it seems that the most reasonable recommendation for substance abuse treatment in detention centers would be a 12-step and/or cognitive-behavioral therapy, there are no clinical data to support this recommendation.

Recognizing that substance abuse rates are high and that detention centers are restricted in their ability to treat such problems in a short time, the Vera Institute of Justice has developed a new program called Adolescent Portable Therapy (APT).[42] The APT program is targeted at detention populations with identified substance abuse problems; however, therapists work with adolescents and their families as they move through the criminal justice system and back out into the community. The program utilizes

principles of family and cognitive-behavioral therapy and has appeal as an innovative approach. However, it has only recently been implemented in New York detention centers, and no clinical data on outcomes are yet available.

Cognitive Behavioral Therapy (CBT)

CBT is an approach to treatment most commonly applied to substance abuse problems. However, elements of this treatment, as well as other related therapies, have been used to address anxiety, depression, and anger management in adolescents. CBT has several features that make it well-suited for application in a juvenile detention setting.

First, it is brief, time-limited, and structured, with an emphasis on treatment gains in a short time. Second, it is present- and problem-oriented, with a goal of immediately reducing current symptoms. Both of these aspects make CBT appropriate in a setting where the length of stay is short and where treatment must be maximally efficient. Third, it is educational, with an emphasis on rehearsal of new skills. This format may be more accessible to a population whose age may limit the usefulness of insight therapies, but whose experience with the education system makes a skills-oriented approach more familiar. Finally, it is directive (i.e., structured and focused by a clinician) but also collaborative, as clients are asked to participate actively and contribute to their own treatment. This may be particularly appealing to adolescents in detention who may be feeling particularly powerless and unable to control the events in their lives.

Of all the treatment approaches discussed in this article, CBT is one of the most extensively tested in juvenile justice populations.[43] In a meta-analysis of treatment interventions for both institutionalized and non-institutionalized juvenile offenders, Lipsey *et al.*[44] found that CBT-style interventions that were short (4–10 weeks) and emphasized interpersonal and behavioral skills showed the most clearly and consistently positive results in outcomes such as episodes of violence and recidivism. Other CBT programs that specifically target life skills[45] and anger management[46–48] have shown similarly promising outcomes.

CBT has not been explicitly tested for its usefulness in treating psychiatric symptoms in detention populations; however, it has been tested as a treatment for substance abuse problems and depression in community samples of delinquents or adolescents who have previously offended. Similar results have been found: it is useful at reducing substance abuse, recidivism, and inpatient utilization.

Medication Management

Psychotropic medication could be administered within the setting under several different circumstances. First, a detainee may be taking medication on entering the facility and if the regimen is interrupted by admission to detention, the detainee's health may worsen. Therefore, current screening recommendations and accreditation standards include an assessment of current medication use so that existing treatment regimens can be extended into the detention setting.

The new prescription of medication in detention could occur in one of two situations—in response to a need perceived by a mental health clinician that is either acute or not acute. If there is an acute need for medication treatment, as determined by a clinician (e.g., florid psychotic or suicidal symptoms), then appropriate use of medication is not only acceptable but ethically required, with the understanding that the treatment plan would be thoroughly documented and reviewed frequently.[28] A failure to treat an acute health need, either physical or mental, would likely be viewed as deliberately indifferent, unconstitutional, and unethical. Facilities that have limited resources to provide such care should have provisions to transfer detainees to other facilities (e.g., the hospital). In addition, efforts must be made to inform parents and clinicians of the treatment plan, and provide for reintegration into community care (e.g., providing links to community mental health services before discharge).

Clinicians may also find themselves being asked by detention staff to address violent behavior through the use of medication. There is no clinically supported evidence (i.e., from treatment trials) for the use of antipsychotic or other medications such as SSRIs to treat impulsive aggression. Current treatment recommendations for aggressive behavior, developed by the Center for Advancement of Children's Mental Health at Columbia University and the New York State Office of Mental Health, support psychosocial interventions as a first option, and only guarded use of medications if such interventions are unsuccessful and if primary psychiatric disorders have been treated first. Clinicians may also be inclined to treat less acute psychiatric symptoms other

than aggression. The recommended classes and types of psychotropic medication available in a facility's formulary will be in part dictated by the size of the facility, average length of stay, and most common psychiatric symptoms encountered. However, such treatment plans should be embarked on with great caution, taking into account the parent and child's attitudes about medication, the likely length of stay of the child, and the availability of community mental health care to continue the treatment plan. State laws will differ on the appropriate use of medications in detention settings, and clinicians should be familiar with the restrictions and guidelines in their own states.[28]

Specific Recommendations

Our specific recommendations are stratified into those that are minimally required and those that would be recommended if expanded mental health services were mandated and/or funded. We recognize that fiscal restraints make the expansion of mental health services in detention facilities unlikely without external pressure and funding.

First, we strongly endorse the NCCHC standards of health care as the minimum required mental health services that should be provided by detention facilities.[28] Many facilities would currently not meet even these minimal standards, and any movement toward meeting these would constitute a major improvement in the juvenile detention system. However, should facilities have the opportunity to expand their services beyond these minimal requirements, we would recommend that qualified mental health professionals (1) establish case management services; (2) provide general supportive counseling to all detainees to address general concerns as well as establish clinical alliances with detainees in need of more extensive mental health care; (3) develop brief drug abuse treatment programs using principles of 12-step and/or CBT strategies; (4) develop strategies to address other psychiatric symptoms, incorporating CBT principles where possible, but also being flexible to include a wide array of therapeutic techniques (e.g., those that use principles of Motivational Enhancement Therapy or the Prochaska stages of change); and (5) forge alliances with community providers to ensure continuity of care across systems once the detainee is released into the community.

Summary

Mental health professionals in juvenile detention settings are working with a population in need of extensive mental health services, and there have been recent improvements in some jurisdictions. However, clinicians in detention settings also face a work environment with several challenges. Short lengths of stay, limited parental involvement, and lack of information on mental health history can hamper the ability to develop a helpful clinical relationship. Unpredictable release dates can hamper the ability of a clinician to conduct termination work or to arrange for appropriate aftercare. Juvenile detention staff, even when well trained, are not hired as milieu or therapeutic staff, again illustrating the limitations of detention as a substitute for a mental health setting. Detainees may be advised by their legal counsel not to speak with mental health clinicians, for fear of compromising their legal case. Finally, there are, at best, minimal current guidelines on the best types of services to offer.

There is need for increased clarity about the intended function of mental health services delivered inside detention settings. Although there is, in some cases, persistent legal pressure to provide behavioral health services in such settings, it is often difficult to establish programs in the face of questions about the appropriateness and effectiveness of therapeutic detention and the vulnerability of mental health professionals who, lacking proper consent, share health information with the courts.

More research on the clinical effects of such interventions is recommended. There have been no studies in which best practices were rigorously tested specifically with detained juveniles, so conclusions have to be drawn in large part from community studies and those conducted in longer-term secure facilities, where population characteristics may differ significantly from those of detention settings.

However, we have highlighted the relevant problems, information, and data that are currently available and have identified a range of services and interventions that could be considered "best practices" in addressing the behavioral health needs of juveniles within the detention center environment. These best practices can guide the efforts of behavioral health professionals who strive to meet the needs of these juveniles today, while we anticipate the findings of

more systematic research that will better guide efforts to meet the needs of this population in the future.

Acknowledgments

We gratefully acknowledge the helpful comments of Joseph Cocozza and David Roush.

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