Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities

ABSTRACT

This practice parameter presents recommendations for the mental health assessment and treatment of youths in juvenile detention and correctional facilities. Mental and substance-related disorders are significant public health problems affecting youths in juvenile justice settings. Sufficient time is necessary to conduct a comprehensive diagnostic assessment, interview collateral historians, and review pertinent records to identify primary and comorbid conditions. Potential role conflicts (i.e., forensic evaluator versus clinical care provider) need to be clarified before beginning any evaluation or treatment program, and particular attention must be paid to the issue of patient confidentiality. Issues of special concern in correctional health care, such as self-mutilative behaviors, suicide attempts, malingering, mandated reporting, ethical issues, cultural competency, institutional policies affecting clinical care, and the role of the clinician, are reviewed. *J. Am. Acad. Child Adolesc. Psychiatry,* 2005;44(10):1085–1098. **Key Words:** practice parameter, practice guideline, child and adolescent psychiatry, juvenile delinquent, juvenile corrections, detention facilities, juvenile justice.

There has been a significant increase in the need for mental health services for youths in the juvenile justice system. Although as many as 75% of juvenile offenders (Teplin et al., 2002) have one or more diagnosable psychiatric disorders, most juvenile correctional facilities do not have the resources to provide services. Although many child and adolescent psychiatrists consult on a part-time or an infrequent basis to community mental health centers, group homes, residential facilities, juvenile detention and correctional facilities, and other juvenile justice settings that house youths with juvenile/family court involvement, there is scant literature regarding effective psychiatric evaluation, consultation, and policy development in these settings. Psychiatrists infrequently receive formal training or continuing medical education regarding these topics. Child and adolescent psychiatrists and other mental health professionals who work in juvenile justice face a myriad of challenges: potential role conflicts, confidentiality issues, interface of multiple systems (i.e., police, probation, family courts, social services), negative perceptions toward delinquent youths, and other practical issues in addressing the multiple needs of these youths.

This practice parameter was written on behalf of the American Academy of Child and Adolescent Psychiatry (AACAP) to provide clinical guidelines for child and adolescent psychiatrists working in juvenile justice settings, but it has broad applicability to other child mental health professionals. Thus, the term *clinician* will be used to define a child and adolescent psychiatrist or

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During July to October 2004, a consensus group reviewed and finalized the content of this practice parameter. The consensus group consisted of representatives of relevant AACAP components as well as independent experts: William Bernet, M.D., Chair; Joseph V. Penn, M.D., and Christopher Thomas, M.D., authors of the parameter; Saundra Stock, M.D., and Jon McClellan, M.D., representatives of the Work Group on Quality Issues; Louis Kraus, M.D., and David Fassler, M.D., representatives of the AACAP Council; William Arroyo, M.D., and Andres J. Pumariega, M.D., representatives of the AACAP Assembly of Regional Organizations; Diane H. Schetky, M.D., independent expert reviewer; and Kristin Kroeger Ptakowski, Director of Clinical Affairs, AACAP.

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any other licensed child mental health professional in these settings.

METHODOLOGY

The list of references for this parameter was developed by searching *PsycINFO*, *Medline*, and *Psychological Abstracts*; by reviewing the bibliographies of book chapters and review articles; and by asking colleagues for suggested source materials. The searches covered the period 1990 through 2004 and yielded about 60 articles. Each of these references was reviewed, and only the most relevant were included in this document.

DEFINITIONS

These are general definitions only, and the reader should be aware of local differences by jurisdiction.

Adjudication

Adjudication refers to a court proceeding in which a delinquency case is reviewed and settled. As used in this guideline, the judicial process for determining guilt in criminal or in juvenile/family courts.

Detention

Detention refers to the period following arrest in which a youth is held in secure custody before or after court proceedings. A detention center, sometimes referred to as a "youth jail," is a short-term secure facility in which. a youth may be held at any time during the processing and disposition of the youth's legal case for the purposes of evaluation or placement if a secure environment is deemed necessary.

Placement

Placement refers to the period following court proceedings in which a judge has issued orders including the location where the youth will reside. Examples of locations may include reception or diagnostic centers, community-based or other residential treatment programs, or juvenile correctional facilities.

Mental Health Professionals

These include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their credentials are permitted by law to evaluate and care for the mental health needs of patients.

Status Offender

Status offender refers to a youth who has violated a law that would not be a crime if the youth were an adult (e.g., curfew violation, truancy, runaway, incorrigibility, underage drinking).

Youthful Offender

Youthful offender refers to any youth found by the juvenile/family court to have committed an offense. Many states have enacted "youthful offender" laws, in which youth charged with certain specific offenses, usually violent or serious crimes, may be automatically transferred to adult criminal court or provided sentences in juvenile court that may extend beyond the maximum age of juvenile court discretion.

YOUTHS IN JUVENILE JUSTICE SETTINGS

Youths with mental illness present a special challenge to the juvenile justice system. Although epidemiological studies on the prevalence of mental and substance-related disorders among youths in the juvenile justice system are limited, research suggests that these problems are significantly more common among youthful offenders than in other youths (Atkins et al., 1999; Cocozza, 1992; Garland et al., 2001). Although as many as 65% to 75% of youthful offenders have one or more diagnosable psychiatric disorders (Teplin et al., 2002; Wasserman et al., 2003), most juvenile detention facilities do not have the capacity to serve them. This situation is aggravated by multiple problems including overcrowding, dilapidated institutions, inadequate funding for services and programs, and inadequately trained custodial and mental health staff. These factors are associated with an increased risk of suicide, physical assaults, and accidental injuries (National Juvenile Detention Association, 2000).

Although there are no current national data regarding the incidence of suicide attempts among youths in custody, the information available suggests a high incidence of suicidal behavior in juvenile correctional facilities. There have been several national studies conducted regarding the extent and nature of suicide in adult jail and prison facilities (Hayes, 2004), but there has not been any comparable national research conducted to date regarding juvenile suicide in confinement. There is only one national survey of juvenile suicides in custody, but this contained several flaws in the calculation of suicide rates (Flaherty, 1980). Reanalyses of suicide rates in that study found that youth suicide in juvenile detention centers was estimated to be

more than four times greater than that in the general population (Memory, 1989). In 1988, the first year of the Children in Custody census, juvenile officials reported 17 suicides occurring in public detention centers, reception/diagnostic centers, and training schools throughout the country. Twenty such deaths were reported during 1994. Given the epidemiological data regarding adolescent suicide, coupled with the increased risk factors associated with detained youths, the number of "reported" suicides in custody appears low. Most juvenile justice clinicians and experts believe the problem to be severely underreported.

There is growing attention to the overrepresentation and disproportionate confinement of minority youths in the juvenile justice system (American Academy of Child and Adolescent Psychiatry, 2001; Krisberg et al., 1991; Pope and Feyerherm, 1993). The Census of Juveniles in Residential Placement (CJRP; Snyder and Sickmund, 1999) revealed that 67% of all confined youths belong to minority groups, although they make up only 34% of the national population. The proportion of minorities confined in private facilities was somewhat less, 55%. The rates of confinement per 100,000 youths were 204 for white, 203 for Asian American, 515 for Hispanic, 525 for Native American, and 1,018 for African American. This disparity in confinement was also found on a state-by-state comparison, although there was some variation.

While girls represented 23% of all cases handled by juvenile courts in 1997 (Puzzanchera et al., 2000), they made up only 14% of all youths in correctional facilities according to the CJRP. The CJRP documented other important sex differences for juveniles in detention and placement. The age distribution is younger for girls: 26% were below the age of 15 compared with only 16% for boys. The proportion of girls was greater in private than public facilities, 18% and 12%, respectively. Girls were also more likely than boys to be in placement for a status offense, representing 45% of all female cases. Although minority girls were overrepresented (51%), the proportion was smaller than that of minority boys (64%). Incarcerated girls also reported high rates of prior abuse, posttraumatic stress disorder, and anxiety disorders, with inadequate resources focused on their sex-specific needs, such as sexual assault counseling. Community-based dispositions for female delinquents continue to be extremely problematic because of the paucity of resources centered on their specific needs.

CHALLENGES TO EFFECTIVE MENTAL HEALTH EVALUATION AND TREATMENT OF INCARCERATED JUVENILES

Numerous issues raise challenges for clinicians working in juvenile justice settings (Thomas and Penn, 2002). Seeing youths in correctional attire, chained, or handcuffed may elicit a wide range of responses in clinicians. Secure juvenile correctional settings present a stark contrast to more traditional mental health treatment settings. Although there are limited systematic data regarding specific ages of youths in juvenile justice facilities, there appears to be an increasing national trend for younger youths, even prepubertal youths, to be incarcerated. In many states, juveniles as young as 9 and as old as 20 are held in the same correctional facility. This wide range of chronological and developmental maturity in juvenile justice youths has multiple clinical implications and is further complicated by differences in (1) offenses ranging from status offenses to more violent crimes (e.g., murder, attempted murder, assault with a deadly weapon); (2) stage of court proceeding and legal status (e.g., detained, preadjudication versus sentenced, postadjudication); (3) legal history (e.g., first-time offender versus repeat offender, multiple incarcerations); (4) gang affiliation; (5) family and psychosocial resources or other supports; (6) youth's and family's attitudes toward law enforcement, the court, state social services, or medical and mental health services; and (7) diversity issues, such as race, culture, ethnicity, religion, and sexual identity.

RECOMMENDATIONS

Each recommendation in this parameter is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets after the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] *Minimal standards* are recommendations that are based on substantial empirical evidence (e.g., well-controlled, double-blind trials) or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time (i.e., in almost all cases). When the practitioner does not follow this standard of care in a particular case, the medical record should indicate the reason.

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence (e.g., open trials, case

studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[OP] *Options* are practices that are acceptable but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases, they may be the perfect thing to do, but in other cases, they should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

Recommendation 1. The Clinician should Have an Awareness and Understanding of the Operations of the Juvenile Correctional Facility and the Issues Affecting it, Including the Interface with Multiple Systems (e.g., Police, Probation, Family/Juvenile Courts, Social Services, Child Welfare Agencies) and the Existing Educational and Health Care Systems within the Facility [CG]

Effective consultation in juvenile justice settings requires knowledge of the organizational structure, policies, procedures, and other systems issues relevant to mental health issues and the routine schedule of youths in the institution (DePrato and Hammer, 2002). Orientation and continuing education activities designed for juvenile correctional facility staff should include training across child service agencies or areas including correctional, educational, health, mental health, and juvenile court. Mental health clinicians benefit from training and orientation by the security staff in the correctional setting, including such matters as social order, gang affiliations, and attitudes toward sexual offenders. Similarly, cross-training can improve the correctional staff's understanding of juvenile's suicide risk factors, psychopathology, and early development, including the sexual and psychological domains. Facility personnel can provide perspective on youths' use and manipulation of the mental health professional and system (American Psychiatric Association, 2000).

Clinicians should collaborate with correctional staff to promote and develop effective mental health programs, attempt to reduce stigma and other biases toward mental health evaluation and treatment, and encourage culturally competent and evidence-based practices. Clinicians also should contribute to and participate in the development of rehabilitative programs for incarcerated youths, including behavioral management; therapeutic, recreational and educational activities; and staff training, policies and procedures relating to these components to enhance the outcome and positive impact on involved youths.

Incarcerated youths are often excellent sources of information regarding institutional rules, security levels, behavioral expectations, and adaptive and covert behaviors demonstrated by some youths. For example, cigarettes, alcohol, illicit drugs, and seemingly innocuous institutional cleaning supplies (spray cans, air fresheners) may be abused by youths in many presumably "secure" or "drug-free" settings.

Clinicians should recognize that although all are working in the "best interests" of an incarcerated juvenile, there is a dynamic tension between the safety, security, and punishment approach by direct-care staff and the rehabilitative or therapeutic approach of clinicians. Each of the institutional service areas has its own legal mandates. Thus, it is paramount to learn the strengths, weaknesses, communication patterns, and relationships among mental health clinicians, direct-care and other professional staff, outside agencies that interface with or provide other services to the juvenile correctional facility, educational staff and systems, and ocal medical staff (e.g., nursing, pediatric, dental).

Clinicians should be attuned to any overly punitive as opposed to rehabilitative efforts by institutional staff. Mandated reporting requirements for the use of excessive force or abuse of incarcerated youths by other youths or staff may vary by state and jurisdiction, and thus clinicians should be knowledgeable about their ethical and local statutory reporting requirements and seek administrative or professional guidance when questions arise.

Recommendation 2. All Youths Entering a Juvenile Justice Detention or Correctional Facility should be Screened for Mental or Substance Use Disorders, Suicide Risk Factors and Behaviors, and Other Emotional or Behavioral Problems [MS]

Numerous studies have documented the higher prevalence of mental disorders and emotional and behavioral problems among youths in the juvenile justice system when compared with the general population. These findings are not entirely surprising because youths charged with offenses would be expected to have

symptoms of conduct disorder (Melton and Pagliocca, 1992). Other mental disorders are also present at rates much higher than those found in the general population, including attention-deficit/hyperactivity disorder, mood and anxiety disorders, and substance use disorders. The potential involvement with substance abuse and violence places many youths at particular risk of posttraumatic stress disorder.

In some cases, youths with serious mental disorders are being routinely detained solely for status offenses or because of a lack of alternate less-restrictive community-based placements; for example, detention centers are used as holding areas because no inpatient bed or residential placement is available (U.S. House of Representatives, 2004).

The prevalence of mental disorders in incarcerated adolescent girls may be much higher than that found in boys. Kataoka and colleagues (2001) found that 80% of incarcerated girls met the criteria for diagnosis of an emotional disorder or substance use/abuse. Another study among incarcerated adolescents diagnosed current PTSD in 49% of the girls, significantly higher than the 32% of boys that met the criteria for diagnosis (Cauffman et al., 1998).

The U.S. Supreme Court set forth minimum requirements for mental health services in correctional placements, including screening and evaluation, in Ruiz v. Estelle (1980). Although this ruling concerned adult facilities, it serves as the basis for broader standards for correctional care, including juvenile placements. Intake screening to identify those in need of mental health care is required for accreditation of correctional facilities by the American Correctional Association and the National Commission on Correctional Health Care (NCCHC). Differences in existing guidelines and standards create wide variations in mental health screening practices across settings (detention, court, corrections, diversion) and jurisdictions (even within the same state) and often do not reflect the highest standard of care (Weibush et al., 1995). In general, youths undergo mental health screening during the first 24 hours of incarceration. In addition, NCCHC standards require a postadmission assessment of all juveniles with positive screens within 14 days of admission (National Commission on Correctional Health Care, 2004).

On arrival at a juvenile justice facility, youths should undergo systematic mental health screening by trained correctional staff and qualified health care professionals. To respond effectively to the high prevalence of mental health and substance abuse problems among incarcerated youths, the intake process should include comprehensive screening for suicide risk, alcohol and other drug abuse, and adjustment to the juvenile justice setting. Policies and procedures regarding referral of youths to mental health or medical personnel should be in place. Intake screening for suicide risk should include questions regarding past suicidal ideation and/or attempts; current ideation, threat, or plan; prior mental health treatment and/or hospitalization; recent significant loss (relationship, death of family member or close friend); history of suicidal behavior by family member or close friend; suicidal ideation or behavior during prior confinement; and initiation or discontinuation of psychotropic medication(s).

The ideal mental health screening tool in juvenile justice should be brief, easily administered and interpreted by facility staff, and proven to identify common problems and safety concerns among newly incarcerated youths. The threshold for referral for a more comprehensive mental health assessment by a mental health professional should also be clearly established in any screening instrument. Many standardized screening and assessment instruments that are routinely used in community settings have not been validated in juvenile justice populations, are overly time intensive, require extensive training or numerous clinicians to administer, or rely on parents or teachers who may not be available. Any potential racial, ethnic, or socioeconomic biases in screening procedures or methods should be removed to ensure fair and timely attention and response (Rogers et al., 2001).

An evidence-based mental health screening should be undertaken as part of the general health screen (Wasserman et al., 2003). One instrument specifically developed to assess youths in the juvenile justice system is the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), a brief 52-item self-report questionnaire (Grisso et al., 2001). Features of the MAYSI-2 include the following: (1) it can be completed within 10 minutes; (2) it uses youth self-report; (3) it is easy to read; (4) it requires no special clinical expertise to administer, score, and interpret; (5) it uses low-cost materials; (6) it may be used with a wide range of adolescents (by age, sex, and ethnicity); and (7) it has sound preliminary psychometric properties. The MAYSI-2 is intended primarily for use at the front door of juvenile

justice systems by nonclinical staff to identify youths who may be in need of immediate clinical intervention (Grisso et al., 2001). The MAYSI-2 shows promise as a reliable and valid screening tool to assist juvenile justice staff in identifying youths who may need immediate response and additional clinical assessment of potential mental or emotional problems.

Recommendation 3. All Youths Held in a Juvenile Justice Detention or Correctional Facility should Receive Continued Monitoring for Mental or Substance Use Disorders, Emotional or Behavioral Problems, and Especially for Suicide Risk [MS]

Even with adequate screening, mental or substance use disorders and other emotional or behavioral problems may not be recognized on intake and only become apparent through additional observation. Newly detained youths are often guarded and suspicious and often present as poor and unreliable historians. In addition, detention or placement in a correctional facility is stressful and may precipitate emotional or behavioral problems that were not present at the time of intake.

In view of the high prevalence of mental disorders and the high incidence of suicidal behavior in youths in juvenile correctional facilities, every juvenile justice facility should have a suicide prevention program for identifying and responding to each potentially suicidal youth. It is therefore necessary for youths held in detention or correctional placements to receive continued monitoring and repeated assessment for emotional or behavioral problems during confinement. Two essential components of a successful suicide prevention program are properly trained staff and ongoing communication between direct-care personnel and clinical staff. Continued observation and reassessment is particularly important in the prevention of suicide for detained youths.

The American Psychiatric Association (APA) Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons (2000) has identified some high suicide risk periods for incarcerated adults and has recommended several key components for an adequate suicide prevention program. Although a youth may become suicidal at any point during incarceration, particularly high-risk periods include initial detention, transfer for court appearance, return to the correctional facility, sentencing, receipt of new legal problems, receipt of bad news, feelings of humiliation or rejection, confinement in isolation or segregation, and a prolonged stay in the facility (National Commission on Correctional Health Care, 2004). Youths with mental and substance-related disorders may pose an even higher suicide risk during any of these periods.

Incarcerated youths may engage in a variety of suicidal and self-mutilative behaviors including threats, wrist lacerations, strangulation or hanging, cell arson, and swallowing foreign objects. Youths who are malingering suicidal behaviors may cause inadvertent serious harm, injury, or complete suicide. Thus, any youth who engages in self-mutilative behavior, even if believed by staff to be manipulative or a gesture for secondary gain, warrants prompt evaluation by a healthcare professional to (1) assess whether additional medical treatment (e.g., debridement, suturing, wound care, bandaging) is needed, (2) clarify whether direct-care staff interventions and special levels of observation are required, (3) initiate evaluation by a qualified mental health professional, and (4) determine whether urgent psychiatric consultation is indicated. Youths who ingest medications or foreign objects or engage in more violent or potentially lethal behaviors (e.g., stabbing, hanging) will likely require emergency medical evaluation.

Recommendation 4. Any Youth with Recent/Current Suicidal Ideation, Attempts, or Symptoms of a Mental or Substance-Related Disorder During the Period of Incarceration should be Referred for Additional Evaluation by a Mental Health Clinician [MS]

Past medical and mental health records are often unavailable, or there may be delays in obtaining releases of information and copies of records. Access to parents, family members, and collateral historians and records is often problematic. After the intake process, should any staff hear a youth verbalize a desire or intent to commit suicide or hear about such a desire or intent from other staff or residents, observe a youth engaging in any self-harm, or otherwise believe a youth is at risk for suicide, a procedure should be in place that requires staff to take immediate steps to ensure that the resident is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained (Hayes, 2004).

Although there are no published standards delineating a specific time frame by which youths who screen positive for suicide risk factors and/or other mental

or substance-related problems on intake should receive additional clinical evaluation, every effort should be made to conduct such an evaluation as soon as possible. Excessive delays, failure to adhere to community standards of care for timely and clinically appropriate referrals, or any negative outcomes would raise liability issues. Youths with acute medical or psychiatric issues, such as delirium, seizures, psychotic symptoms, or evidence of substance intoxication or withdrawal, and those in need of acute mental health services beyond those available at the facility warrant immediate evaluation by a qualified mental health professional (National Commission on Correctional Health Care, 2004) and/or immediate transfer to an appropriate medical treatment setting. Some juvenile justice facilities' relationships with appropriate medical and psychiatric treatment settings may be limited or inadequate. The clinician may help solidify these relationships so that transfers may occur in an efficient manner.

Recommendation 5. Clinicians Working in Juvenile Justice Settings must be Vigilant about Personal Safety and Security Issues and Aware of Actions that may Compromise their Safety and/or the Safety and Containment of the Incarcerated Youths [MS]

Before entering any facility, the clinician must become aware of (1) the type and functioning of the correctional facility (i.e., staff secured, facility secured, medium versus maximum security), (2) personal safety issues (in the event of a fire alarm, altercation, riot, hostage situation), (3) the location and physical surroundings in which the evaluation will be conducted, (4) the proximity and methods of accessing correctional staff in the event of any problems, and (5) what to do and where to go upon completion of the interview. The clinician and youth should be afforded a quiet evaluation site (ideally in a clinic setting) that ensures confidentiality and is conducive to conducting the diagnostic interview while maintaining safety and security.

Recommendation 6. All Qualified Mental Health Professionals should Clearly Define and Maintain their Clinician Role with Youthful Offenders and their Family Members [MS]

It is critical for clinicians working in juvenile justice settings to define and maintain their role as a clinician as opposed to as an agent of the court or of the state. This role delineation is especially important during preadjudication with detained youths. Laws, professional ethics, and administrative rules usually limit mental health clinicians in the degree to which they can provide treatment while a youth awaits trial. Additional restrictions placed on clinicians may exist with specific court-imposed no-contact orders that prohibit interrogation regarding an alleged offense without the presence of legal counsel. Treating psychiatrists must be aware of their state mental health codes.

Because results of any medical or mental health assessment become part of the juvenile's correctional health record, clinicians making written entries should be attentive to legibility and careful documentation. In particular, clinicians should refrain from recording specific details regarding the youth's criminal offense or, alternatively, if thought to be clinically necessary, should list only the alleged offense(s). Information that a clinician obtains from a youth may compromise the youth's defense if the clinician is called to testify (Grisso, 1998).

Because of concerns of potential role conflicts and confidentiality issues, it is extremely important to maintain strict role boundaries if any treatment is initiated with detained or pretrial youths. Some practical suggestions for therapists may include the avoidance of exploration into the details or circumstances of the alleged criminal act(s), the youth's state of mind, criminal intent, mitigating factors, or defense strategies. Another role that demands careful clarification for the youths and family is court-mandated or forced treatment, in which clinicians are required to provide periodic updates to the court or a designee (e.g., probation officer) regarding compliance and progress in treatment.

Clinicians should be extremely careful regarding verbal or written communication with attorneys and other court personnel, and they should avoid inappropriate communication with the media. Responses to media requests regarding specific youths should be declined and instead directed to appropriate juvenile justice administrative personnel. If asked to evaluate youths who are charged with particularly heinous or high-profile crimes, clinicians should be especially mindful of all communications to correctional and clinical staff, parents, and family members. Even confirmation of having seen a specific individual may represent a violation of confidentiality. After adjudication, the issues of any court-ordered treatments, including the therapist's role, agency, and mandated reporting to the court or

probation office, should be delineated for the youth and family.

Recommendation 7. Adequate Time and Resources are Needed to Perform a Mental Health Assessment of Incarcerated Youths using a Biopsychosocial Approach with Special Attention to Cultural, Family, Gender, and other Relevant Youth Issues [CG]

Clinicians working in juvenile correctional facilities will perform various types of evaluations. These include problem-focused brief mental health assessments at the time of admission such as assessment of a youth's suicide risk or determination of the appropriate level of services needed for a youth. These brief assessments may result in the implementation of additional supervision such as "suicide precautions," transfer to an alternate setting, referral for a more comprehensive mental health evaluation, or other treatment recommendations.

A more comprehensive postadmission mental health assessment may require several hours to complete (American Academy of Child and Adolescent Psychiatry, 2003) and may include a structured diagnostic interview and review of available health care records and collateral sources of information. The postadmission mental health assessment includes more detailed inquiry into the youth's history of psychiatric hospitalizations and outpatient treatment, family history (including psychiatric history), current and prior use of psychotropic medications, treatment responses, suicidal ideation and history of suicidal behavior, drug and alcohol use, history of sexual offenses, violent behavior, victimization or abuse, special education placements, history of cerebral trauma or seizures, and emotional response to incarceration (National Commission on Correctional Health Care, 2004). Clinicians should document a diagnostic formulation and an initial treatment plan (American Psychiatric Association, 2000).

All evaluations of youths in juvenile justice settings require an assessment for substance use disorders and withdrawal symptoms because of the high percentage of youths with this problem and the association of recidivism and substance use problems in this population (Randall et al., 1999). Clinicians should work together with medical staff to enable facilities to intervene early in assessing and treating chemical dependency including withdrawal symptoms (National Commission on Correctional Health Care, 2004).

Although a clinician may diagnose conduct disorder and possibly comorbid substance abuse such as alcohol and cannabis abuse, it is crucial to assess for additional comorbid conditions. The clinician should also identify psychosocial stressors such as the adjustment to an out-of-home placement, peer teasing, conflict with peers and staff, and limited visitation by family members.

A complete developmental, social, and medical history is a part of any comprehensive assessment involving adolescents (American Academy of Child and Adolescent Psychiatry, 1997). Clinicians should attempt to gather relevant collateral information whenever possible from family members; clinical, educational, and correctional staff; previous service providers; treatment records; and educational records. It should include an assessment of the youth's strengths and available resources in addition to any problems and deficits. This information will be instrumental in identifying the youth's past behavioral patterns, prior level of functioning, adaptation to incarceration, disruptive or problematic behaviors, interaction with peers and staff, and overall level of impairment, adjustment, and functioning in a correctional unit setting.

All newly incarcerated youths require educational evaluations and, on adjudication, will require an individualized treatment plan using the multidisciplinary role of educators and clinicians. It is helpful for clinicians and educational personnel to communicate because ongoing communication between clinicians and educators enhances both treatment and education. Some youths may already have a previous special education designation with an individualized education program, which should be implemented in the facility.

Also, some youths may benefit from additional evaluations, including psychological testing; specialized educational, speech, and language assessment; occupational or physical therapy evaluation; or additional specialized assessments such as evaluation for substance abuse, fire setting, and sexual offender or neurological consultation.

When performing any type of mental health evaluation of an incarcerated youth, it is critical for clinicians to use a biopsychosocial model with attention paid to unique adolescent developmental, peer, gender, cultural, religious, and family issues. Clinicians should also evaluate for histories of trauma, peer and family relationships and functioning, and family psychopathology, including domestic violence, physical and sexual abuse,

and family criminality, substance abuse, or mental illness. A detailed assessment of the youth's past exposure to violence and perpetration of violent or illegal behaviors is essential. Clinicians should also carefully elicit any history of high-risk behaviors, such as unprotected intercourse, promiscuity, multiple sex partners, gang activities, prostitution, running away, comorbid eating, somatoform, and gender-identity disorders.

Recommendation 8. Clinicians should be Alert to Symptoms, Behaviors, and other Clinical Presentations of Malingering, Secondary Gain, and Manipulative Behaviors by Incarcerated Juveniles [CG]

Facing the prospect of incarceration, it is not surprising that some youths may malinger, feigning suicidality or other psychiatric symptoms. Clinicians should be aware that some psychiatric symptoms such as hallucinations, delusions, physical complaints, self-mutilative behaviors such as actual or attempted ingestion of chemicals or foreign objects, superficial cutting, or other actual or threats of self-injury may be attempts to avoid incarceration or to be placed into a perceived less restrictive and more therapeutic environment (e.g., medical hospital, psychiatric hospital) or alternatively a nonsecure setting for possible elopement. Although structured interviews and additional psychological testing may be helpful, the mainstay of diagnosis remains a high index of suspicion combined with careful data collection and ongoing assessment for discrepancies in historical information and for clinical inconsistencies in the mental status examination. It is important to collect collateral information when suspicions of malingering arise; staff observations are particularly invaluable. This additional information will help to identify inconsistencies and discrepancies commonly found in adolescent malingerers (McAnn, 1998; Oldershaw and Bagby, 1997).

Recommendation 9. All Clinically Referred Youths should be Evaluated for Current and Future Risk of Violent Behavior [CG]

At the time of detention or adjudication, many juvenile justice facilities routinely conduct nonclinical (e.g., based largely on number, type, and severity of past legal offenses; assaultive behaviors toward staff or peers; other disciplinary infractions during prior incarcerations) or clinical "risk assessments" of newly incarcerated youths in an attempt to triage youths with violent crimes or a history of violence to more secured and contained settings and to maintain safety for confined youths, correctional staff, and clinical staff. For example, youths with histories of sexually offending behaviors or sexual victimization may require special observation, placement, or housing.

Although psychiatrists cannot predict dangerousness with definitive accuracy, they can often identify risk factors associated with an increased likelihood of violent behavior (American Psychiatric Association, 2001). Exploration into the youth's history of violence should include such variables as how chronic or recent as well as the frequency, severity, and context of violent behavior. The clinician should clarify the youth's history of exposure to domestic violence, past physical and sexual abuse and other traumatic events, perpetration of violence against others (e.g., cruelty to animals, bullying, fire setting, sexually assaultive behaviors), substance abuse, and other risk factors for future violence. In addition, a standardized approach should be used to elicit a history of weapon possession, access to and use of weapons pre-incarceration, and assaultive or threatening behaviors against peers or staff before or during incarceration (American Academy of Child and Adolescent Psychiatry, 1999; Pittel, 1998; Schetky, 2002).

Recommendation 10. Mental Health Professionals should be Aware of Unique Therapeutic and Boundary Issues that Arise in the Context of the Juvenile Correctional Setting [CG]

Aside from maintaining issues of personal safety and security, clinicians should be attuned to youths, family, institutional staff, and clinician interactions and relationship issues and should strive for clearly defined therapeutic clinical boundaries with incarcerated youths, families, and staff. Clinicians may feel overly sympathetic toward some youths or alternatively hostile, resentful, or angry toward youths with antisocial personality traits, juvenile sexual offenders, or youths allegedly involved in heinous or high-profile crimes. Understandably, many youths and their families view incarceration as unfair or punitive and see any other alternative legal disposition as preferable. For a variety of reasons, including the perceived loss of control or power during courtroom proceedings, families may seek other assistance or interventions from clinical staff, such as writing a favorable letter to the court. Alternatively, some families with a history of unfavorable interactions with juvenile justice or other agencies may shun or be suspicious of evaluation or treatment efforts by clinical staff. This may present in the form of not returning

telephone calls, not signing releases, refusing treatments offered, or not attending family therapy or treatment planning meetings. Identifying these and other dynamics and appreciating relevant cross-cultural, family, and religious issues can be crucial.

Clinicians working in juvenile justice settings should be attuned to institutional and staff perceptions and behaviors toward youths in their custody and any allegations or observation of abusive behaviors toward any youths. Mandated reporting requirements for use of excessive force or abuse of incarcerated youths by other youths or correctional staff may vary by state and jurisdiction, and clinicians should follow their local statutes or reporting requirements.

Recommendation 11. Clinicians should be Knowledgeable about the Facility's Policies and Procedures Regarding Seclusion, Physical Restraints, and Psychotropic Medication and in Support of Humane Care should Advocate for the Selective Use of Restrictive Procedures Only When Needed to Maintain Safety or When Less Restrictive Measures have Failed [CG]

As a general rule, without a court order, any use of psychotropic medications needs to be voluntary and not coerced or forced on a youth, except during psychiatric emergencies. Clinicians should be especially careful to avoid the use of psychotropic medications for staff benefit. Clinicians should have knowledge of current institutional seclusion and restraint policies and procedures. In general, current national standards require written institutional or department policy and defined procedures for the appropriate use of therapeutic restraints for patients under treatment for a mental illness (American Academy of Child and Adolescent Psychiatry, 2002). The NCCHC, the American Correctional Association, and other national organizations that develop health care standards for correctional facilities have created and promulgated national guidelines and standards for the use of punitive (restraints by properly trained direct-care staff for immediate control of behavioral dyscontrol) versus therapeutic restraints (restraints for youths under treatment for mental illness) in juvenile correctional facilities. They specify the types of restraint that may be used and when, where, how, and for how long restraints may be used. A physician or other qualified health care professional as allowed by the state health code authorizes the use of therapeutic restraints in each case on reaching the conclusion that no other less restrictive treatment is appropriate. Physicians should use caution and discretion in using restraints in youths with histories of sexual abuse and be vigilant about the risk of airway obstruction with prone restraints and/or excessive pressure on a youth's back. For restrained patients, the treatment plan addresses the goal of removing juveniles from restraint as soon as possible. The health care staff does not participate in the nonmedical or punitive restraint of incarcerated juveniles except for monitoring their health status (National Commission on Correctional Health Care, 2004).

Recommendation 12. Clinicians should use Psychotropic Medications in Incarcerated Juveniles in a Safe and Clinically Appropriate Manner and Only as Part of a Comprehensive Treatment Plan [CG]

Clinicians often will evaluate youthful offenders presenting with insomnia, depression, disruptive behaviors, or other symptoms and initiate referrals to psychiatrists for further diagnostic evaluation and possible psychotropic medication treatment. Many youths in the juvenile justice system are taking multiple medications when initially detained, whereas others have never received medications; a comprehensive mental health assessment, when clinically indicated, provides an opportunity to reassess their treatment needs. The current literature on the use of psychotropic medications in juvenile justice settings is limited, and the emerging medication studies on the treatment of youths with conduct disorder are confined to outpatient studies with small sample populations. If psychotropic medications are used, then they should augment a comprehensive and individually developed mental health treatment plan with the youth's compliance and active participation including the modalities of individual, group, and family therapy and other appropriate treatment interventions. Clinicians can also recommend the implementation of behavioral interventions and strategies such as regular exercise and improved sleep hygiene, encouragement of available family members and other social supports to rally around an incarcerated youth, facilitation of additional staff supervision and support, development of additional supportive relationships with both peers and direct-care staff, and use of other correctional, clergy, and community resources.

Psychotropic medications should be used with great caution and only after reviewing the potential

risks, benefits, side effects, and alternatives with the youth and the youth's parent or legal guardian if the youth is still a minor. Generally speaking, signed informed consent is needed for minors according to particular state mental health code. Multiple psychotropic medications—polypharmacy—should be used judiciously because of numerous potential risks and possible medication interactions and side effects. Newly detained youths taking one or more psychiatric medications require careful assessment and monitoring, and attempts should be made to serially reevaluate the youth or gradually reduce the need for multiple medications. Ideally, to ensure that the treatment trial can proceed in a safe and supervised fashion, a youth's legal disposition and placement should be clarified or resolved before any psychiatric medication is reduced or initiated.

As with any mental disorder, it is unwarranted to prescribe psychotropic medications in the absence of distinct target symptoms or when placement and mental health follow-up services are unclear. Issues that are particularly relevant with detained youths include weighing the risk–benefit of the proposed psychotropic medication: the medication's risk in overdose, side effects, anticipated youth and family compliance with medication and follow-up treatment, prescription coverage and health plan benefits, and the potential for diversion (e.g., psychostimulants). The youth's clinical treatment team should reassess the need for previously prescribed psychotropic medications on the basis of current symptoms, level of functioning, and treatment needs. Many juvenile justice youths have a history of mental health treatment noncompliance and may have abused or been noncompliant with stimulant medications.

Clinicians and direct-care staff must be aware of the potential abuse of psychiatric medications, as well as trading medication for money or sexual favors or its use as barter goods. Clinicians should educate nursing staff, other clinical staff, and direct-care staff when appropriate and should review the evaluation and management of medication noncompliance, including surreptitious behaviors such as "cheeking" medications.

Finally, clinicians should assess a youth's medication compliance and perform ongoing follow-up and monitoring for the emergence of problematic side effects. It is important for clinicians to explore the circumstances and rationale for a youth's pattern of medication refusal with the youth, clinical team, other relevant staff, and the youth's family when indicated.

Recommendation 13. Clinicians should be Involved in the Development, Implementation, and Reassessment of the Youth's Individualized Treatment Plan While in the Correctional Setting and with the Planning Process for Re-entry to the Community that Best Incorporates Multidisciplinary, Culturally Competent, Family-Based Treatment Approaches [CG]

As with any mental health intervention, planning should begin with the indicated treatments for the disorders and symptoms identified by a thorough evaluation. Treatment should include consideration and implementation of a full range of both psychosocial and psychopharmacological interventions and should incorporate as broad a range of disciplines and modalities as indicated. The recommendations and treatment plan should be clearly written in a way that is understandable and useful to court and others who will need the information to assist with implementation of treatment.

Numerous therapeutic strategies can be used across various juvenile correctional settings including individual, family, and group therapy modalities. Kazdin (2000) described the evidence in support of parent management training, cognitive problem-solving skills training, functional family therapy, and multisystemic therapy. Cognitive problem-solving skills training describes a broad range of treatments that seek to correct the deficits in interpersonal skills that antisocial youth exhibit, especially problem solving in conflicts with family members, authority figures, and peers and conflict resolution with peers regarding perceived or actual threats. Anger management and verbalization skills are also included in some treatment programs. Because of the high prevalence of substance use disorders in juvenile offenders, youths should receive substance abuse education and prevention training. Multisystemic therapy is an evidence-based intervention that uses a multimodal approach to address the typically multifaceted issues relating to delinquency (Henggeler et al., 1998; Schoenwald et al., 1996). Multisystemic therapy is one of only a few community-based treatments with proven efficacy in this population.

Apart from treatments directed at antisocial behaviors and substance use, there is limited research

on treatment of other mental health problems among delinquents. Model programs have been developed that advocate better integration of mental health care between juvenile justice settings and community-based levels of care. One example is Milwaukee Wraparound, which demonstrated cost-effective reductions in recidivism and improved mental health services for delinquents (Kamradt, 2000). An important feature of this systems approach to providing treatment is the continuity of care across settings.

Discharge planning in a juvenile correctional setting is defined as all procedures for an incarcerated youth in need of additional mental health or substance abuse treatment at the time of release from the correctional setting to the community to obtain continuing care. There are additional challenges to effective postrelease treatment planning and family involvement. Some examples include (1) the premature release of a youth to the community without appropriate services in place and (2) the placement of a youth in a distant or out-of-state location. There are several national efforts (e.g., Office of Juvenile Justice and Delinquency Prevention, Coalition for Juvenile Justice) to reduce the recidivism and provide opportunities for the successful reentry of youthful offenders returning to their communities from juvenile correctional facilities. Failure to follow up with mental health services after release from detention or placement is a significant problem with young offenders (Lewis et al., 1994). It is important for any mental health professional to be aware of the continuing research and advances in treatment as well as the availability of services in the community to assist in disposition planning.

Recommendation 14. It is Paramount that Clinicians Working in Juvenile Justice Settings are Aware of Relevant Financial, Fiscal, Reimbursement, Agency, and Role Issues that may Affect their Ability to Provide Optimal Care to Incarcerated Youths and Consultation to the Juvenile Correctional System [OP]

Both public and private correctional facilities handle detained and committed youths. Although there are currently about twice as many private facilities, they hold less than half the number of youths detained in public facilities (Snyder and Sickmund, 1999). Since the 1984 changes in federal regulations regarding Medicaid, responsibility for financing health services to youths in juvenile justice facilities has shifted from federal to state or local governments, creating health care disparities. There is a growing trend in juvenile corrections and juvenile justice facilities away from traditional state support to privatization, and in many settings, certain evaluative and treatment functions are further contracted to private "for-profit" corporations or groups.

Because of this variability by jurisdiction (i.e., county, state, region) and the growing phenomena of privatization and a managed care model, clinicians should have an understanding of (1) the existing or proposed infrastructure and payment/reimbursement model for mental health evaluation and treatment delivery; (2) various roles and responsibilities (caseload, expected daytime availability, after-hours and emergency coverage); (3) volume of referrals and amount of time per evaluation, collateral contact, and follow-up evaluations; (4) any expectations regarding training and supervision of other mental health or correctional staff; and (5) any financial or other administrative constraints that may limit or ration appropriate treatment and care and thus increase medicolegal and other liability issues. Clinicians should be aware that the same professional standards and most of their state regulations pertaining to clinical practice apply to the services that they provide in juvenile correctional settings.

Clinical work in any correctional setting can be frustrating, and burnout is an inherent risk. Clinicians are encouraged to participate in professional activities, pursue continuing medical education, and communicate with colleagues working in correctional facilities to share experiences and provide mutual support. Clinicians should be aware of other organizations in addition to the AACAP involved in advocacy regarding mental health issues in juvenile justice settings including the American Psychiatric Association, American Academy of Psychiatry and the Law, Society of Correctional Physicians, and the National Commission on Correctional Health Care.

CONCLUSION

Numerous challenges confront mental health professionals serving the needs of incarcerated juveniles. Effective screening, timely referral, and appropriate treatment require interagency collaboration, adherence to established standards of care, and continuing research on the mental health needs of youths in the juvenile justice system. This will require continued development and

validation of mental health screening and other assessment tools in juvenile correctional settings. In addition, more research is needed on the prevalence of mental illness and the efficacy of various treatments for juvenile offenders to provide improved mental health services and effective transition upon release. Clearly, better mental health care for youths in the juvenile justice system serves the intended goal of rehabilitation.

SCIENTIFIC DATA AND CLINICAL CONSENSUS

Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision-making. AACAP practice parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The clinician, after considering all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources, must make the ultimate judgment regarding the care of a particular patient.

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