

# **Mental Health Screening in Juvenile Facilities**

***Q&A Prepared for TASC of NAPAS  
By Center for Public Representation***

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**Q. There have been two recent suicides in juvenile detention centers in our state. Newspaper accounts state that the adolescents had been only recently confined and imply that the detention center staffs were not aware the youths may have had mental health difficulties. We want to begin to advocate for institutionalized juvenile offenders with disabilities. We hope to begin by learning whether improved screening for mental illness in juvenile facilities might be effective in preventing further suicides.**

**A. As you increase your advocacy for institutionalized juvenile offenders, there will be many elements of the system that will bear investigation and scrutiny. Screening and evaluation is good place to begin.**

## **1. The scope of the problem.**

**Although precise estimates for specific disabilities vary, studies suggest that between 30 and 50 percent of incarcerated youth have a disability that would qualify them for special education services. A review of the literature by the National Council on Disability (NCD) reported the following about incarcerated youth:**

- between 10 and 36 percent have a specific learning disability;**
- upwards to 50 percent have an emotional disturbance, with as many as 20 percent meeting the standards for severe emotional disturbance;**
- as many as 12 percent are labeled as mentally retarded; and,**
- attention deficit hyperactivity disorder is four to five times more prevalent in juvenile detention facilities than in schools, and between 20 and 50 percent of incarcerated youth are believed to have ADHD.**

**Nat'l Council on Disability, *Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current Status of Evidence-Based Research*, 57-58 (2003).**

**The results of a Cook County, Illinois study, completed after the publication of the NCD's review, are even more startling. The research concluded that one-half of the juvenile detainees studied had at least *two* mental health**

disorders and that one in ten had both a major mental disorder and a substance abuse disorder. Significantly more females than males met the criteria.<sup>1</sup> Karen M. Abram, et al., *Comorbid Psychiatric Disorders in Youth in Juvenile Detention*, 60 Arch. Gen. Psychiatry 1097 (2003).<sup>2</sup>

NCD notes that nearly all the research is limited by design and implementation problems. However, whatever the shortcomings of the research, it is clear that a significant number of incarcerated youth have disabilities, and of those, emotional difficulties and mental illness should be a major concern.

## **2. Alternatives to institutionalization**

Conditions for children, particularly those with mental disabilities, in juvenile detention facilities are a national scandal. Recent reports on conditions in the California Youth Authority's (CYA's) facilities found the system's mental health services to be in "complete disarray." One report said that the vast majority of youths with mental health needs "are made worse instead of improved by the correctional environment." John M. Broder, *Dismal California Prisons Hold Juvenile Offenders*, New York Times, Sunday, February 15, 2004, p. 12. See, Rudy Haapanen & Hans Steiner, *Identifying Mental Health Treatment Needs Among Serious Institutionalized Delinquents Using Paper-and-Pencil Screening Instruments, Final Report to the National Institute of Justice*, U.S. Dept. of Justice, July 2003 (evaluating CYA's mental health and substance abuse screening process); Eric W. Trupin & Raymond Patterson, *Report of Findings of Mental Health and Substance Abuse Treatment Services to Youth in California Youth Authority Facilities*, December 2003 (evaluating CYA's mental health and substance abuse treatment services). Unfortunately, California is not the only state with a troubled and dangerous youth detention system.

Dr. Arrendonodo puts it very starkly:

From a developmental point of view, prolonged detention is also problematic because the child is undergoing developmentally important phases of life in institutional settings with idiosyncratic demands particular to that setting. Consequently, the child is adapting to incarceration and an institution, not the community from which she came and to which she will return. *It is imperative that the juvenile justice decision-maker understands that virtually every effective evidence-based intervention for delinquency occurs in the home and the community.*

David E. Arrendonodo, *supra* n. 1, 14 Stanford L. & Pol'y Rev. at 20 (emphasis supplied). Therefore, advocates should consider strategies which

will divert youth from detention facilities.

There are numerous kinds of diversion programs, some of which may be controversial.<sup>3</sup> In response to litigation, Connecticut has developed a useful model that specifically addresses screening and assessment. More than 10,000 children cycle through that state's juvenile justice system each year and at least 3,000 are incarcerated in its juvenile detention centers. A recent study confirmed that at least 60% of the incarcerated children exhibit mental health needs upon admission.

Children's advocates in Connecticut filed a class action law suit in 1993 alleging a pervasive pattern of constitutional violations in conditions of confinement at the three Connecticut detention centers. Although the state remedied many environmental deficiencies, five years later the federal court held that mental health care offered at the facilities continued to violate the Constitution. The parties negotiated a comprehensive corrective action plan that established both criteria for screening and evaluation in the detention centers and obligated the state's child welfare agency to collaborate with the juvenile justice agency to develop a system to screen, evaluate, and treat nonviolent offenders in the community, rather than in detention. See, Order for Supplemental Relief, *Emily J. V. Rowland*, No. 3:93CV1944 (RNC)(D. Conn. June 24, 2002) (adopting Joint Corrective Action Plan).

The Plan has revamped the entire delivery system of mental health evaluations and treatment for young offenders in Connecticut. It mandated a unique collaboration between the state's juvenile justice and probation programs and its mental health and child welfare systems. Implementation progress has been uneven, but the agreement holds out hope for alternatives to

institutionalization.

Therefore, in developing advocacy strategies for serving institutionalized youth with disabilities, P&A advocates should begin by considering alternatives to institutional detention.

### 3. Components of a mental health system in a detention setting

Fruitful places to look to determine what mental health services should be available in juvenile facilities are the standards of various professional and accreditation groups. There are several sets of national standards governing juvenile detention centers. They include *Standards for Juvenile Detention Centers* developed by the American Correctional Association in conjunction with the Commission on Accreditation for Corrections (3rd ed. 1991, with

1994 Standards Supplement), the *Standards for the Administration of Juvenile Justice* developed by the National Advisory Committee to the Office of Juvenile Justice and Delinquency Prevention and a multi-volume series promulgated by the Institute for Judicial Administration/American Bar Association in 1979. In addition, several separate standards published by the medical community also relate to care in juvenile detention centers. Michael J. Dale, *Lawsuits and Public Policy: The Role of Litigation in Correcting Conditions in Juvenile Detention Centers*, 32 U. San Francisco L. Rev. 675, 715 (1998).<sup>4</sup>

For those juvenile offenders who are detained in facilities, there is general agreement among the standards, the literature, and court opinions that an effective mental health system in detention setting should have the following components:

- a systemic process for screening and evaluation of new admittees to identify mental health problems;
- available services that are more than segregation or close supervision;
- trained mental health staff in sufficient numbers;
- complete, accurate, and confidential records;
- the prescription and administration of psychiatric medications by qualified staff in a professionally acceptable manner;
- identification, treatment, and supervision of detainees with suicidal tendencies
- crisis intervention services for short-term treatment;
- the availability of acute care mental health services in a hospital or hospital like setting;
- long-term care, including special needs housing, for those who cannot be integrated into the general population of the facility;
- outpatient services;
- consultation; and,
- adequate discharge and transfer planning.

See, e.g., Curtis Heaston, et al., *Mental Health Assessment of Minors in the Juvenile Justice System*, 11 Wash. U. J. of L. and Pol'y 141 (2003); J.L. Metzger, *An Introduction to Correctional Psychiatry. Part III.*, 26 J. Am. Acad. Psych. & Law 107-15 (1998). See, also,

*Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D. Tex. 1980), aff'd in part and rev'd in

part, 679 F.2d 1115 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983)(adults). Of these components, perhaps the most effective as deterrents to suicide are the adequate screening and assessment of youth when they are first admitted to a facility. Screening, intake assessment, and related components of an adequate mental health system in a detention facility, as they are described in the standards, the literature and the case law, are discussed below.

#### **A. Screen/initial assessment**

Confidential mental health screening, performed by health-trained or qualified health care personnel, should be done for all youth upon the arrival at the facility. Receiving screening should be performed by qualified health care personnel on all youth immediately upon their arrival at the facility. The purpose of the screening is to identify possible suicide risk, psychiatric, medical, substance abuse difficulties, and developmental and learning disorders.<sup>5</sup>

The comprehensive and very instructive settlement agreement in *Williams v. McKeithen*, 121 F.Supp. 2d 943, 996-97 (M.D. La. 2000), resolving several law suits challenging conditions at juvenile facilities in Louisiana, requires an initial screening at admission to assess whether the youth is experiencing “significant current psychiatric difficulties, suicide ideation, or homicidal ideation.” The *Williams* settlement also requires that all detained youth have an “intake mental health evaluation,” by a mental health professional, within 14 days of admission. This more in-depth evaluation must include an interview with the offender, psychological screening, assessment of intelligence and adaptive functioning, collateral interviews and a records review.<sup>6</sup> *Id.*

#### **B. Emergencies**

The facility should have the capacity and have procedures in place for the immediate referral of anyone identified to need crisis or emergency mental health services in the initial screening. The *Williams* decree requires that if the initial screening determines any significant mental health problem or suicidal or homicidal ideation, the youth must be seen within 24 hours by a qualified mental health professional and retained in a “crisis bed” in the meantime. 121 F.Supp. 2d at 996.

#### **C. Medications**

Psychiatric medication must be prescribed and monitored by a psychiatrist, preferably a child psychiatrist, in accordance with contemporary medical standards. In some cases, medication may be overseen by a non-psychiatrist physician or clinical nurse practitioner who is supervised by a child

psychiatrist. Psychiatrists or physicians should monitor all inmates on psychotropic medications.<sup>7</sup>

The *Williams* decree requires that if a youth comes to the facility with a prescription for psychotropic medication, he must be seen by a psychiatrist within 24 hours and have a full evaluation within a week. 121 F. Supp. 2d at 997-98.

#### **D. Other components.**

Perhaps many suicides that occur shortly after admission can be prevented by adequate screening and intake evaluations. But, continued assessment and appropriate services are necessary throughout each youth's stay in the facility. The elements of an adequate mental health service system are discussed in the standards and in the *Williams* agreement.

#### **3. Advocacy strategies.**

Increased media and public attention to conditions in juvenile facilities may offer timely and excellent advocacy opportunities. However, any advocacy efforts will necessarily have to be undertaken against resilient and persistent impressions that some of today's youth are irredeemable predators.<sup>8</sup> Advocates will necessarily have to challenge prevailing myths about supposedly violent youth.

A comprehensive discussion of advocacy strategies is beyond the scope of this paper. However, P&As should at least consider administrative advocacy, publicity, legislative advocacy, and, as a last resort, litigation. P&As' statutory access rights apply to juvenile detention facilities and advocates will be able to learn a great deal about the system through monitoring, investigations and individual representation.

Professor Bernadine Dohrn of the Northwestern University School of Law's Children and Family Justice Center strongly suggests creating alliances with both youth groups and with now-successful adults who were in the juvenile justice system when they were younger.<sup>9</sup> Such alliances can provide powerful testimony both to the vast shortcomings of the system and the resilience and hope of the children and youth who are part of that system.

Whatever advocacy strategies are chosen and pursued, P&As can expect the work to be challenging and difficult, but the potential rewards to be plentiful.

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<sup>1</sup> There is an increasing interest in the differences in case dispositions, treatment needs, and confinement conditions, between male and female young offenders. See, e.g., David E. Arrendonodo, *Child Development, Children's Mental Health and the Juvenile Justice System: Principles for Effective Decision-Making*, 14 *Stanford L. & Pol'y Rev.* 13, 20 (2003); Leslie Acoca & Myrna S. Raeder, *Severing Family Ties: The Plight of Nonviolent Female Offenders and Their Children*, 11 *Stanford L. & Pol'y Rev.* 143 (1999). Like gender, race and ethnicity are often important factors in how a youth is treated in and experiences the juvenile justice system in general and detention in particular. "The proportion of minority youth involved in the juvenile justice system greatly exceeds the proportion of these youth in the general population" Arrendonodo, 14 *Stanford L. & Pol'y Rev.* at 27, citing Heidi Hsai & Donna Hamparian, *Disproportionate Minority Confinement: 1997 Update*, *Juv. Justice Bull.* (Office of Juvenile Justice and Delinquency Prevention, U.S. Dep't of Justice), Sept. 1998, at 3. Consideration of these very important issues is beyond the scope of this brief paper.

<sup>2</sup> Studies indicate a lower (between 15 and 36 percent), but still significant, number of adult offenders with co-occurring disorders. Stanley Sacks & Frank S. Pearson, *Co-Occurring Substance Use and Mental Disorders in Offenders: Approaches, Findings and Recommendations*, 67 *Fed. Probation* 32 (2003).

<sup>3</sup> For example, Los Angeles has established a juvenile mental health court designed to divert young people from the detention and juvenile justice systems. See, Andrea DiGiovanni, *Juvenile Mental Health Court: An Innovative Approach to Crime, Violence, and Delinquency Among Our Youth*, 23 *J. Juv. L.* 1 (2002-03). For a description of some other diversion services see, Coalition for Juvenile Justice, *Handle with Care: Serving the Mental Health Needs of Young Offenders* (2000), available at [www.juvjustice.org](http://www.juvjustice.org). Some adult models are described in Stanley Sacks & Frank S. Pearson, *supra* n. 2, 67 *Fed. Probation* at 34-36.

<sup>4</sup> Although standards can be very helpful in advocacy, they ultimately may be of limited assistance in litigation. On the one hand, compliance with standards does not ensure that an institution will survive a constitutional challenge in the courts. Professor Dale cites *In G.C. v. Coler*, No. 87-6220-Civ-Gonzalez (S.D. Fla. Dec. 15, 1988) (Settlement Agreement) in which the Broward County Regional Juvenile Detention Center in Fort Lauderdale, Florida, had

met the American Correctional Association standards and had been certified by that organization. Yet it was the subject of a successful lawsuit which resulted in a consent decree in 1989. On the other hand, some courts have held that the standards cannot be used to set a minimal level for the operation of the institution. Michael J. Dale, 32 U. San Francisco L. Rev. at 715.

<sup>5</sup> Courts have held the Eighth Amendment requires a process to identify mental health needs at admission of adult prisoners and pre-trial detainees. See, e.g., *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995) (finding Eighth Amendment violation where "defendants do not have an adequate mechanism for screening inmates for mental illness, either at the time of reception or during incarceration").

<sup>6</sup> Many facilities use the Massachusetts Adolescent Screening Inventory (MAYSI II) either for screening or for assessment. Thomas Grisso, et al, *Massachusetts Youth Screening Instrument for Mental Health Needs of Juvenile Justice Youths*, 40 J. Am. Acad. Child & Adolescent Psychiatry 541 (2001). The *Williams* decree requires that it be used as part of the intake evaluation. Because of its wide use, advocates interested in screening and intake evaluations may benefit from a familiarity with the MAYSI.

<sup>7</sup> Several courts have addressed the administration of psychiatric medications in adult facilities. See, e.g., *Madrid v. Gomez*, 889 F. Supp. 1146, 1258 (N.D. Cal. 1995) ("Psychotropic or behavior-altering medication should only be administered with appropriate supervision and periodic evaluation."); *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995) (finding constitutional violations in part because inmates on psychotropic medication are not adequately monitored).

<sup>8</sup> According to Physicians for Human Rights, the United States is the only country in the world (with the possible exceptions of the Congo and Iran) that executes child offenders.

[www.phrusa.org/campaigns/juv\\_justice/call\\_to\\_abolish\\_a.html](http://www.phrusa.org/campaigns/juv_justice/call_to_abolish_a.html). See also, the Florida appellate court decision overturning the life sentence without the possibility of parole for Lionel Tate, who was just 12 years old when he committed the offense (first degree murder) for which he was convicted. *Tate v. State*, \_\_\_ So. 2d \_\_\_, 2002 WL 22900994 (Fla. D.Ct. of Appeal, 4<sup>th</sup> Dist., 2003).

<sup>9</sup> The Center's publication *Second Chances* tells the powerful stories of numerous successful adults who were once in the juvenile justice system. The book is available through links from the clinical page of

[www.northwestern.law.edu](http://www.northwestern.law.edu).

