Ch.11 Mental Health

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"Something is wrong with this kid. I don't know what it is, but he's definitely going to have a hard time being locked-up here."

—Juvenile Correctional Officer

Youth with mental health disorders continue to enter and remain in juvenile detention, corrections, and adult jails and prisons. Some of these youth are mildly disturbed; others have a serious mental illness. Their ability to function in a facility can be compromised by:

- Severe attention and concentration problems.
- Serious mood disorders.
- Histories of repeated trauma.
- Unusual and bizarre thinking.
- Self-destructive behavior.
- Low intellectual functioning.
- Issues related to alcohol or other drug use.
- Aggression and violence.

Youth in custody with mental health disorders are a mixed group. Within the same week, staff may work with youth who have ADHD and struggle with rigid rules and stimulating living units, youth who hear voices, those who smear their feces on walls, and those who try to take their own lives.

The numbers of incarcerated youth are decreasing, dramatically in some states. The remaining population of juveniles in custody tends to be the most 1) violent, 2) criminal, 3) mentally ill, and 4) challenging to treat. This is a difficult and potentially dangerous combination, and one of the biggest challenges currently facing facilities that house juveniles.

How Many Youth in Custody Have a Mental Health Disorder?

The exact number of juveniles in custody with mental health disorders is currently unknown, however, research consistently shows that incarcerated youth suffer from significantly more mental illness than youth in the general population. Studies of youth in custody have found 63% to 92% met formal criteria for a mental health or substance use disorder.[1] When one of the studies removed conduct disorder and substance use disorders, almost half of youth still met criteria for a mental health disorder. The need is great for large-scale, standardized studies on incarcerated youth with mental health and substance use disorders to identify exactly how many are suffering and the nature of their conditions.

Suicide thoughts and attempts are more frequent among youth in custody; extreme levels of irritability and aggression are common, and self-injury is not unusual.[2] Gang members have high rates of mental health disorders, and youth with learning disorders are three times more likely to become gang members.[3] Many incarcerated youth have been exposed to serious, sometimes life-threatening trauma during childhood and adolescence.

Participation in outpatient mental health therapy is common among this population, and close to one-fifth has been hospitalized in inpatient mental-health facilities—with some youth requiring multiple hospitalizations.[4] Youth in correctional facilities and youth in psychiatric hospitals share more similarities than differences, and juvenile justice staff may often feel as if they are working at a mental health facility.[5]

Juvenile Justice Facilities Are the New Default “Mental Health” Facilities
Accessing quality mental healthcare has become increasingly difficult for adolescents, especially those from low-income communities or those who exhibit delinquent or aggressive behavior. Residential “treatment” options for youth with serious mental health disorders have shrunk; many psychiatric hospital programs for adolescents have closed. Of those remaining, many are hesitant to accept youth with criminal or violent histories—some refusing outright to admit them. Even when juveniles are admitted, brief inpatient stays are the norm.

Long waiting lists and ineffective outpatient treatment is typical. When their mental health deteriorates, mentally ill youth frequently engage in behaviors—some minor, some serious—that bring them to the attention of law enforcement. The juvenile justice system has become the default placement for many youth with mental health disorders who do not receive appropriate psychological and psychiatric treatment in the community. This is particularly true for minority youth who are over-represented in the juvenile justice system and under-represented in the mental health system. A government report found that “the unnecessary detention of youth who are waiting for mental health treatment is a serious national problem.”[6] When families of youth with mental health disorders were surveyed, over one-third reported that their children were placed in juvenile justice facilities because needed services were unavailable.[7] In addition, “zero-tolerance” school policies and an increase in school resource officers have resulted in more youth with mental health disorders being referred to the juvenile justice system for behaviors that in the past were handled by teachers and school administrators.[8]

**Common Mental Health Disorders Among Incarcerated Youth**

Following are the most common mental health disorders seen among youth in custody. See the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) for detailed descriptions of each condition;[9] subsequent sections explain how each mental health disorder specifically manifests among incarcerated youth.[10]

- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Posttraumatic Stress Disorder (PTSD)
- Oppositional Defiant Disorder (ODD)
- Conduct Disorder
- Major Depression
- Persistent Depressive Disorder or Dysthymia
- Disruptive Mood Dysregulation Disorder (DMDD)
- Bipolar Disorder
- Specific Learning Disorders (Learning Disabilities)
- Intellectual Disability (previously known as Mental Retardation)
- Fetal Alcohol Syndrome (FAS)

Youth can become psychotic (e.g., lose touch with reality; have difficulty differentiating fantasy from reality) if suffering from schizophrenia, bipolar, depression, or substance use disorders.

**Most incarcerated youth with mental health disorders suffer from two or more impairing conditions simultaneously.** The assessment and treatment of these juveniles becomes more clinically complex with each additional disorder. Plus, having co-morbid mental health disorders during adolescence can also raise juvenile offenders’ risk of recidivism during young adulthood.[11]

Because of intense suffering or problems functioning in day-to-day activities, some incarcerated youth require specialized mental health services, despite not meeting criteria for a formal mental health disorder, according to the DSM. Use of the DSM is the main way, but not the only way, to determine which juveniles suffer from psychopathology. The National Institutes of Mental Health (NIMH) has moved away from DSM categories and is developing a new classification system of mental disorders that is potentially very relevant to the mental health struggles seen among incarcerated youth.

Substance Use and Co-Occurring Disorders

Studies of youth in custody have found rates of substance use disorders ranging from 37%–86%.[12] Therefore, a significant number of youth require formal treatment for their problematic use of alcohol or other drugs. Co-occurring disorders refers to the simultaneous presence of both a mental health and a substance use disorder. One study found that one in ten incarcerated youth had depression, bipolar, or schizophrenia and a substance use disorder.[13] Rates of substance use disorders co-occurring with conduct disorder and ADHD are likely even higher. The assessment, treatment, and management needs of juveniles with co-occurring disorders are different and more complex than those who suffer from only one condition. Individuals with co-occurring disorders have been shown to have:[14]
Higher rates of future criminal behavior.
- Relationship problems.
- Higher rates of depression.
- Poor compliance with psychotropic medication.
- Higher rates of hospitalization.
- A lower likelihood of successfully completing treatment.

Juveniles with co-occurring disorders are also at increased risk of dying by suicide.[15]

**Head Injury and Brain Trauma**

Many incarcerated juveniles have had experiences in which damage to their brain could have occurred: physical fights, car accidents, a blow to the head as a child, being shaken as a baby, falling from trees or down stairs, excessive drug use, being beat up, jumped by gang members, and others.

Some incarcerated youth experienced trauma to their brain before birth; during pregnancy, their mother:

- Used alcohol or other drugs.
- Did not receive appropriate prenatal care.
- Was malnourished.
- Was infected with an illness.
- Gave birth prematurely before the youth’s brain was fully developed.
- Experienced birth complications (e.g., decreased oxygen to baby’s brain).

Studies show that one in four to almost one in five incarcerated youth suffer from traumatic brain injury.[16] Most of these injuries are unidentified.

Incarcerated juveniles with damage to the front part of the brain, where the “executive” functions reside, typically have difficulty:

- Planning ahead.
- Accurately judging situations.
- Controlling their emotions.
- Prioritizing what to pay attention to.
- Controlling their behavior.

Therefore, these youth have a hard time:

- Following rules or directives.
- Delaying immediate gratification.
- Behaving appropriately when obstacles and challenges are present.
- Keeping their emotions under control.
- Learning from consequences or past mistakes.

In response to their negative behavior, youth in custody with head trauma frequently lose privileges and spend time in isolation. Some are restrained; many end up in the adult system. Decision-makers are typically unaware of juveniles’ brain damage, therefore, the misguided perception that these are “bad” kids making “bad” choices drives placement and programming decisions.

Comprehensive neuropsychological assessments are rarely obtained for incarcerated youth, primarily due to the high financial cost and minimal access to neuropsychologists. A relatively brief neuropsychological screening should be conducted with youth who exhibit persistent aggressive or violent behavior, as well as with impulsive, emotionally unstable youth who cause significant disruption to a living unit or facility. If neuropsychological screening detects an issue, juveniles should be referred for a comprehensive neuropsychological battery. The cost of this type of assessment is high, but less than the physical and financial resources spent unsuccessfully managing these youth.

**Trauma Among Youth in Custody**

Trauma among incarcerated juveniles is the rule, not the exception. One study found 93% of youth in custody had at least one traumatic incident; over half had experienced trauma six or more times.[17]
The following are common in the history of incarcerated youth:

- Witnessing someone being badly hurt or killed.
- Extreme parental or caregiver neglect.
- Physical, sexual, or emotional abuse.
- Domestically violent home.
- Removal from family home.
- Placement in foster care or residential treatment setting.
- Raised in filthy home with insects, rotting food, broken windows, no beds, and minimal food.
- Sleeping in the same room with adults engaging in sexual activity or forced to watch pornography.
- Victim of sex trafficking or prostituting their bodies.
- Forced by parents or caregivers to have sex with strangers in exchange for drugs.
- Locked in closets, cages, cars, or basements.
- Being shot or stabbed.

Many of these traumas occurred during childhood, when youth did not possess the intellectual or emotional capacity to process frightening, disturbing, or painful events. The adults children depended on for stability, protection, and love were often those who caused the most harm. These adults, as well as others who could have helped youth cope with the aftereffects of traumatic incidents, were frequently struggling with their own issues. Hurt people hurt people.

Interpersonal traumas (e.g., abuse, neglect, witnessing domestic violence, separation from parents) tend to have the most negative impact on young people. Depression, anxiety, PTSD, attention problems, substance abuse, as well as aggressive, delinquent, and violent behavior, are all associated with having experienced traumatic events; and parental or caregiver neglect is at least as damaging as physical and sexual abuse.[18]

Many incarcerated youth have experienced “poly-victimization”—multiple forms of victimization experienced by a single child. The greater the number of traumatic experiences, the more damage to a child or adolescent. Compared to other traumatized youth, those who have experienced numerous different types of traumas are:[19]

- At double the risk of developing depression.
- Three times more likely to develop PTSD.
- Three to five times more likely to abuse alcohol or other drugs.

They are also at higher risk of:

- Engaging in delinquent behavior.
- Struggling in school.
- Running away.
- Becoming suicidal.

Experiencing multiple types of maltreatment is associated with “reactive aggression” (e.g., impulsive, angry aggression in response to perceived provocation versus aggression to obtain status, power, or material goods).

Posttraumatic Stress Disorder (PTSD) Among Incarcerated Youth

Studies of youth in custody find rates of PTSD ranging from 10%–50%,[20] which is remarkably high, given that the rate of PTSD among youth in the general population ranges from 6%–8%.[21] and the rate of combat-related PTSD among soldiers returning from Iraq or Afghanistan is estimated to range from 4%–17%.[22] Almost all incarcerated youth who suffer from PTSD also suffer from another mental health or substance use disorder, with half suffering from two or more disorders in addition to PTSD.[23] Youth who experience multiple traumas but do not meet the full criteria for PTSD experience similar distress and problems in daily life as those formally diagnosed with PTSD.[24] Therefore, juveniles who experience impairment due to trauma-related symptoms should be referred for treatment, regardless of whether they qualify for a PTSD diagnosis.[25]

The DSM criteria for PTSD fits well with a one-time event that shocks or terrorizes an individual (e.g., rape, car accident, witnessing a murder), rather than the chronic, multiple interpersonal traumas many youth in custody experience. Studies of justice-involved youth have found that 57% experienced four or more traumatic events, and half have experienced six or more traumas.[26]
Because of the limitations of the PTSD diagnosis, modified diagnoses have been proposed—Complex Trauma, Complex PTSD, and Developmental Trauma Disorder—to better account for the impact of multiple, prolonged, inescapable trauma on 1) a youth’s mood, attention, and behavior, 2) his or her brain, and 3) key areas of a youth’s life.[27] Unfortunately, none of these diagnoses were formally listed in the most recent manual of mental disorders (DSM-V); however clinicians and researchers are increasingly integrating Complex Trauma, Complex PTSD, and Developmental Trauma Disorder models when screening, assessing, and treating juveniles with lengthy histories of multiple victimizations to more accurately and effectively meet the needs of this highly victimized group. See the National Child Traumatic Stress Network (NCTSN) for more information on trauma, Complex PTSD, and Developmental Trauma Disorder.

Misdiagnosis of Trauma and PTSD among Youth in Custody

Despite their high rates of trauma, multiple types of victimization, and associated suffering, most youth in custody are not diagnosed with a trauma-related condition or referred for trauma-related treatment. This is due to the following:

- Trauma is often misdiagnosed as another mental health disorder (e.g., symptoms of trauma can look very similar to symptoms of ADHD, depression, bipolar, personality disorders, psychosis, and conduct disorder).
- Chronic or heavy alcohol or other drug use to cope with traumatic experiences may be solely diagnosed as a substance use disorder.
- Screening and assessments often do not ask about traumatic events.
- Even when asked, incarcerated boys tend to underreport physical and sexual abuse, as well as any suffering related to traumatic experiences.
- Boys tend to exhibit their distress in anger, irritability, and aggression and so are seen as bad youth versus traumatized or sad youth.

Research has found that one in six boys has been sexually abused, although this may be an underestimate.[28] The rate of sexual abuse among incarcerated boys is unknown, but is likely even higher than estimates for the general population, because many youth in custody were raised in environments that placed them at increased risk (e.g., instability, interpersonal conflict, living with one parent, domestic violence, experiencing additional forms of abuse). According to Holmes and Slap, sexual abuse among boys is “common, underreported, under-recognized, and undertreated”; harmful effects include, depression, anxiety, PTSD, paranoia, physical symptoms, anger, aggression, difficulty in school, running away from home, and delinquency.[29]

Some incarcerated youth have been given three, four, or five mental health and substance use diagnoses due to exhibiting a multitude of problems in multiple areas. Most clinicians do not consider that some or all of these symptoms may stem from an underlying core of trauma.

Trauma Changes the Brain

Early and severe trauma (particularly physical, sexual, and verbal abuse; neglect; domestic violence) can change the brain and central nervous system, as well as cause neuroendocrine abnormalities.[30] Faced with threatening situations (violent families and communities), the body automatically goes into “fight or flight” mode and releases certain chemicals. When these chemical responses in the brain are continually reactivated, it can lead to structural, molecular, and functional changes in a youth’s brain.[31] these negative changes are associated with significant academic, social, and behavior problems.

Repeatedly traumatized youth can become biologically wired for survival—always revved up, tense, and reactive. They constantly scan the environment for signs of a possible threat, and then impulsively respond. Not surprisingly, these youth often see danger, a threat, or an attack when none exists. A basic request from staff is perceived as a challenge. In casual conversations, they hear disrespect when none was intended. Traumatized youth are particularly keyed into non-verbal signals (e.g., inflection and tone of voice, body posture, how close someone is standing to them). These automatic reactions are intensified in facilities when youth feel unsafe with staff or peers. Youth whose brains have been impacted by multiple traumas are difficult to manage because of the following:

- Unpredictable moods.
- Difficulty calming down once upset.
- Angry outbursts that are often out-of-proportion to what initially provoked them.
- Apparent lack of concern for others.
- Minimal impact of sanctions and negative consequences.
- Minimal response to psychotropic medication.
Violence and delinquency are complex, multi-determined behaviors. It is not being suggested that trauma and multiple victimizations caused youth in custody to engage in them. However, the role of complex trauma among youth in juvenile detention, corrections, and adult facilities must be addressed and integrated into screenings, assessments, and interventions —especially among youth at the “deep end” of the system.

Re-traumatization

The combination of irritability, anger, fear of being seen as weak or vulnerable, and impulsivity often results in youth with significant trauma receiving multiple sanctions while in custody due to negative and sometimes dangerous behavior. Youth must be held accountable, including those who have been traumatized; however, staff should be aware that re-traumatization can occur when youth are:

- Confined and locked in small rooms.
- Physically restrained, especially by multiple staff members at once.
- Physically searched, especially when the search is invasive.

The following can also trigger traumatic thoughts and emotions:

- Being stripped of clothes or put into a safety smock after reporting thoughts of suicide.
- Being observed by staff or harassed by peers while showering.
- Witnessing or directly experiencing physical or sexual assaults.
- Receiving no visits from family or caregivers.
- Not being told important information.
- Intrusive room checks in the middle of the night.
- Intimidating and violent peers.
- Antagonistic and harsh staff.

These situations can exacerbate feelings of vulnerability and loss of control, which often triggers an automatic, biologically programmed fight or flight survival response. When he or she is re-traumatized, a youth’s belligerent, destructive, or aggressive behavior is likely to escalate in intensity and duration. Not surprisingly, at this point, staff typically respond with more intensive supervision or control, physical restraint, or some form of isolation. This tends to further trigger youth, resulting in even more aggression, belligerence, or destructive behavior, which leads to longer or harsher sanctions. As the cycle continues, both youth and staff are at increased risk of getting hurt.

It is tragically ironic that juvenile justice facilities are one of the most difficult environments for traumatized youth —yet their traumatic histories often play a major role in the delinquent or violent behavior that gets them there.

Mental Health Screening and Assessment

To manage and effectively treat juveniles with mental health and substance use disorders, facilities must be able to identify these youth, their challenges, and their strengths. Doing so increases the likelihood that those who work with these youth will:

- Refer them to qualified mental health professionals.
- House them appropriately.
- Use strategic and effective management strategies.
- Provide effective clinical treatment.
- Prescribe psychotropic medication only to youth who truly need it.

Accurately identifying juveniles with mental health and substance use disorders also helps reduce youth aggression, assaults, and suicide. Mental health “screening” and “assessment” are integrally related, but are not the same.

Mental Health Screening

Mental health screening is a brief (30 minutes or less) procedure primarily used to detect youth who may have a mental health disorder and are in need of further evaluation. Conducted early in the process of confinement, screening typically includes an interview and mental health checklists or questionnaires. Screening tools should be simple enough for a variety of professionals (including non-clinical staff) to administer, or for youth to complete on their own. They should be available in different languages, or facilities should have access to someone who can translate them. Every juvenile in custody should receive a mental health screening, regardless of his or her estimated length of stay.

https://info.nicic.gov/dtg/print/6
When mental health screening identifies juveniles as possibly having mental health symptoms, youth should receive a more extensive assessment to explore the nature and severity of the symptoms, as well as determine the necessity of specialized treatment services. Mental health screening is not designed to provide a mental health diagnosis and should not be used for that purpose.

All youth in custody should be screened for mental health symptoms 1) upon entry to a facility, 2) each time youth move to a new placement (e.g., detention, correctional facility, work camp, ranch, group home), 3) if youth display dramatic changes in behavior, or 4) if staff suspect mental health symptoms.

At a minimum, mental health screening should include questions about:

- Current or past mental health symptoms, self-injury, suicidal thoughts or behavior.
- Current or past mental health treatment, psychotropic medication.
- Current or past use of alcohol or other drugs, substance abuse treatment.
- Cognitive or intellectual limitations.
- Recent or past traumatic events.
- Current or past aggressive or violent thoughts and behavior.
- Current support system.
- Strengths and resiliencies or protective factors.
- Degree of insight regarding need for treatment.
- Observation of juveniles’ behavior (e.g., appearance, attitude, speech, mood).

If a youth is overtly intoxicated or extremely agitated, staff should delay mental health screening until they can elicit compliance and obtain reliable results. Youth should not be placed in general population until the screening is completed.

Professionals conducting the screening should know about 1) mental health symptoms, 2) normal adolescent development, 3) the stress of incarceration, and 4) signs of intoxication and withdrawal. Juvenile justice professionals who administer a brief mental-health screening tool at intake do not need to have the same mental health knowledge as psychologists, but their knowledge and training must be appropriate to the task at hand. (See Ch. 9: Admission and Intake) [9]

Referrals to Mental Health Professionals

Staff should refer youth to a qualified mental health professional (QMHP) within the facility if 1) “red-flags” are identified on screening tools, 2) youth exhibit moods or behaviors of concern, 3) they ask to speak with a QMHP, or 4) their parents or caregivers request it.

All facility staff should have access to the mental health referral process, as they are valuable observers of youth behavior. Requiring supervisors to sign-off on formal mental health referral slips submitted by staff helps them remain informed regarding a youth’s struggles.

According to the National Commission on Correctional Health Care (NCCHC), QMHP include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. [32]

Mental Health Assessment

Mental health assessments typically occur after youth have been identified in the screening process as having a possible mental health disorder. More comprehensive than screening, assessments often take hours to complete, and results provide the foundation for treatment planning within the facility and as youth prepare for transition back to the community. Assessments go into more depth on issues covered in the mental health screening; they explore additional key areas of a youth’s life. Youth are queried about their thoughts, feelings, and behavior.

Clinicians should assess a youth’s level of functioning—psychologically, intellectually, emotionally, and socially—to better understand the areas of challenge and success.

Specific diagnostic criteria from the DSM are used to establish whether a youth has a mental health disorder; if so, clinicians determine the scope and severity. Carrying a mental health diagnosis has major ramifications; therefore, clinicians who assign
Mental health diagnoses to youth should have formal training in the 1) screening and assessment of mental health disorders among youth and 2) provision of mental health diagnoses among youth. **Mental health diagnoses should only be assigned after a comprehensive and thorough mental health assessment.**

Mental health assessments should include:

- A clinical interview with youth.
- Tests of cognitive and intellectual functioning.
- Personality tests.
- Rating scales and checklists regarding youth moods and behavior.
- Information from individuals familiar with a youth's functioning, including family members.
- Behavioral observations.

Short stays in detention facilities typically do not provide enough time for comprehensive mental health assessments that include psychological testing and the provision of a diagnosis. In these situations, QMHPs should spend as much time as is feasible assessing a youth’s mental health, developing plans that address immediate issues that may impede his or her success in the temporary setting, and communicating key information to individuals who supervise and interact with youth.

Mental health, substance use, and trauma should not be assessed in isolation because the three are highly interrelated, with overlapping symptoms. When youth have **co-occurring** mental health and substance use disorders, clinicians should examine how the two conditions interact. Because of the significant trauma histories among incarcerated youth, clinicians should evaluate the effect trauma plays in a youth’s moods and behavior before assigning a mental health diagnosis. Situational factors should also be taken into account before diagnoses are made; youth who react to a temporary stressor must be distinguished from those with true mental health disorders.

Mental health diagnoses are of little value to staff without detailed recommendations. Therefore, assessment results should be summarized in written form and integrated into daily programming, treatment, and transition plans. Clinicians should write in terms understandable to a youth’s family and professionals in various disciplines and should provide face-to-face feedback to youth regarding key findings.

**Mental Health Reassessment**

Youth with mental health disorders need periodic reassessments to determine whether their diagnosis (or lack thereof) and current treatment plan remain accurate. Serious mental health disorders may increase in severity as youth move into late adolescence; in contrast, a youth’s depressed mood, anxiety, or suicidal thoughts may disappear after a major stressor is removed. Reassessment is typically necessary if mentally ill youth exhibit a dramatic change in mood or behavior or experience major stress, or when there is reason to believe a previous mental health evaluation was unreliable or invalid.

**Strength-Based Mental Health Screening and Assessment**

Many confined youth have experienced tragedy, trauma, and crisis. Their strength and resiliency is often one of the primary reasons they survived—physically and emotionally—and these assets should be identified and explored. Rather than asking only about problems, difficulties, and areas in which youth struggle, mental health screening and assessment should also ask about areas in which juveniles have achieved or excelled. Questions about behaviors youth may be embarrassed or ashamed about should be balanced with questions about hobbies, interests, and areas that make them proud. Youth with mental health disorders are more than their pathology, diagnosis, or label. A strength-based approach does not entail overlooking criminal behavior or ways youth have harmed others; it strives for a more balanced approach. Taking a broader view of juveniles with mental health disorders demonstrates to them that adults are interested in knowing about each of them as a whole person.

**Culturally-Sensitive Mental Health Assessment**

Professionals who conduct mental health screenings and assessments with youth from various minority groups must be alert to cultural issues. Clinicians can misinterpret youth responses as signs of mental illness if unfamiliar with their background. For example, having visions of deceased relatives during periods of grieving is an accepted experience in some cultures and not viewed as hallucinations. Fearful youth exclaiming “they’re all after me” can be perceived as paranoid when rival gang members or others in the facility may truly be threatening them. By the same token, clinicians who rely on stereotypes of youth who are different than they are (e.g., culture, race, gender, sexual orientation) can overlook or automatically dismiss mental health symptoms, assuming they are just part of youth culture.
Youth from various racial and ethnic backgrounds can manifest mental health symptoms differently. Some mental health instruments have been developed for middle-class Caucasian males, so results may not be valid when assessing youth of other races, backgrounds, or another gender. In addition, parents or caregivers have often sought assistance for their mentally ill children from clergy, extended family, tribal healers, or curanderos; therefore, screening and assessment should broaden questions about previous treatment beyond outpatient or inpatient psychotherapy.

**Which Screening and Assessment Instruments Are Best?**

Using the same or similar screening and assessment tools throughout an entire juvenile justice agency—and within key partnering agencies—can facilitate more efficient and effective communication within and across systems. Standardized (administered the exact same way every time) instruments, with research evidence that demonstrates that they are reliable and valid, should be the first-line tools. Most mental health instruments were not developed for use with incarcerated youth, and some have limited validity for young women or minority youth. Non-research-based standardized screening tools can be used as a supplement; they typically contain questions that directly ask about specific behaviors such as “do you cut yourself to feel better?” or “what medication are you taking?” During all phases of the assessment process—test administration, scoring, interpretation, and reporting of results—individuals who administer mental health screening and assessment tools must take into account the strengths and limitations of the instruments they use and the population for whom they were developed.

See Boesky and Grisso, Vincent, and Seagrave, for a list of standardized mental health instruments used with youth in custody.[34]

**Self-Report Information: Can We Believe What Incarcerated Youth Tell Us?**

Most incarcerated youth answer honestly if directly asked about mental health symptoms. But they may inadvertently provide inaccurate information if intoxicated, do not have good memories, or have difficulty verbalizing their internal experience. Some youth deliberately minimize or exaggerate mental health symptoms, intentionally manufacture them, or deny them completely. Youth may minimize or deny mental health symptoms to avoid:

- Being seen as weak, vulnerable, weird, or crazy.
- Taking psychotropic medication.
- Placement on a specialized unit or room.
- Extra monitoring by staff.

Some seriously suicidal youth deny having thoughts of killing themselves so staff will not try to stop them.

Youth in custody may exaggerate or fabricate mental health symptoms because they want to:

- Talk and spend time with a variety of professionals.
- Obtain mind-altering psychotropic medication.
- Be placed on a special unit or in a special room.

A few standardized mental health tools were designed to detect youth who are hiding or faking symptoms. These validity scales are particularly useful when assessing incarcerated youth, as are specialized tools that detect “malingering.”

The screening and assessment of youth with mental health, substance use, co-occurring, and trauma-related disorders is an ongoing process, especially in juvenile detention and adult jails where youth may be admitted with alcohol or other drugs in their system.

**Mental Health Treatment**

The treatment needs of youth with mental health disorders do not decrease or disappear when they enter juvenile detention, corrections, or an adult facility; on the contrary, their needs may intensify due to the stress of incarceration. Just as juvenile justice provides medical services to youth with external physical injuries, the system must also respond to a youth's internal mental health symptoms. This responsibility is detailed in national standards[35] and recent class action lawsuits (e.g., incarcerated youth with serious mental health disorders have a constitutional right to mental health treatment).[36]
Correctional facilities are not inpatient psychiatric hospitals, nor should they be treated as such. These settings must be given appropriate funding and resources to provide intensive mental health services when, by default, they are expected to serve that role.

Regardless of the type of correctional setting, the goals of mental health treatment include:

- Stabilize youth’s emotions and behavior.
- Maintain safe facilities and orderly living units.
- Reduce youth suffering and impairment in key areas.
- Decrease self-destructive behavior.
- Facilitate opportunities for youth to succeed while incarcerated.
- Teach youth necessary skills to better control their emotions and behavior.
- Teach youth necessary skills to function more successfully in the community.

Successful mental health, substance abuse, co-occurring, and trauma-related interventions address all areas of a youth’s life, including family, peers, school, community, or when necessary—youth’s physiology (through medication). This mission is more difficult when youth are incarcerated, but the goal remains the same. Providing effective mental health treatment is not only best practice, it also reduces the likelihood of a large lawsuit, something common in recent years.

Except in rare circumstances, mental illness is not an 

- **cause** for youth breaking rules or laws. Accountability is essential in facilities—and having a mental health disorder does not change that. However, youth should not be sanctioned or punished for their mental health symptoms. This issue can be complicated when a youth’s mental health symptoms manifest in aggression and harm toward others, which is why mental and corrections staff must work together closely when sanctioning a youth with mental health disorders.

### Involving Parents or Caregivers in Mental Health Treatment

Parents or caregivers experience a variety of emotions when their children with mental health disorders are incarcerated. Amidst hope that their children will receive treatment, they also worry that their vulnerable sons or daughters will be victimized while in custody. If they do not believe their children are mentally ill, parents or caregivers may be troubled upon hearing that facility clinicians want to prescribe psychotropic medication or other treatment services. They want to participate in the decisions that affect their children, but may not know how to become involved or have the resources and supports to do so. Time and energy must be devoted to engaging parents or caregivers in the assessment and treatment process to increase their motivation and foster positive treatment outcomes.

If parents or caregivers cannot attend in-person meetings, consider participation by conference call, webcams, Facetime, or another communication option. Efforts should be made to include fathers, even if they are only distantly involved in a youth’s life. Parents or caregivers should be encouraged to call the facility with questions or concerns about the mental health treatment of their children.

**Strategies to Engage Youth and Their Parents or Caregivers in Treatment**

For youth confined for more than a month, the following strategies can engage parents or caregivers and maintain their involvement as treatment progresses:[37]

- Clarify what treatment is and what it is not (can differ pre- versus post-adjudication).
- Set realistic treatment goals that are meaningful to juveniles and their families.
- Update parents or caregivers regularly regarding the status of their child’s behavior.
- Provide immediate responses to positive and negative youth behavior.
- Follow through on all promises made to juveniles and their parents or caregivers.
- Acknowledge and attempt to address other problems with which youth and their parents or caregivers are concerned.
- Ensure that all professionals in the facility, regardless of discipline, send a consistent message on critical issues.
- Treat youth and their parents or caregivers with respect at all times.

Allowing parents or caregivers to ask questions, provide input, and participate in decision-making is empowering and makes it more likely they will support and commit to the treatment process. Parents or caregivers should be educated on the benefits and risks of each treatment option, including psychotropic medication.

Treatment agreements help parents or caregivers understand what treatment will entail and the type of participation the practitioners expect of them. Treatment agreements reduce miscommunication and can be referred to if miscommunication
should arise; they should be written and reviewed verbally with all parties. Treatment agreements should include 1) a description of the treatment process, 2) the goals of treatment, 3) limitations of treatment, and 4) information about relapse. [38]

Strength-Based Interactions with Parents or Caregivers

Parents or caregivers of incarcerated youth with mental health disorders have often had professionals point out what they were doing “wrong” raising their children, as well as in their own lives. Acknowledging their positive characteristics and effective parenting choices decreases apprehension and self-protection and increases motivation. Staff should balance questions about youth difficulties with questions about youth success (no matter how small); inquire about parents’ or caregivers’ fears and concerns about their children and what makes them most proud. Avoid language that implies that something is bad, wrong, or a problem and instead use words such as “challenge” and “struggling.” When incarcerated, juveniles and their parents or caregivers frequently feel hopeless about the situation or their child’s future. In such cases, staff might ask how they survived hardships and difficulties in the past. Many have overcome major obstacles, tragedy, and heartbreak, and some continue to cope with significant daily stressors. Staff should recognize and highlight these assets and strengths.

From the start, staff should reinforce participation in treatment with youth and their parents or caregivers; this helps increase the chance of completing treatment, should things become difficult. The following incentives can increase motivation to attend treatment sessions at the facility:

- Transportation to or from the facility.
- Food during treatment sessions.
- Time for youth and their families to visit after sessions are over.
- Verbal praise and acknowledgment.
- Certificates of achievement.
- Rituals for completed tasks or goals.
- An extra phone call between youth and their parents or caregivers later in the week.

Regardless of their age, size, and strength, most youth in custody appear genuinely moved and touched when receiving praise from their parents or caregivers in response to their efforts or progress. Ask youth and their parents or caregivers what would be most motivating for them.

Informed Consent for Psychotropic Medication

Parents or caregivers should be contacted for their informed consent if youth are prescribed psychotropic medication. They should be told:

- The mental health conditions youth suffer from.
- The psychotropic medication to be prescribed.
- Potential benefits and risks of the prescribed medication.
- Potential benefits and risks of alternative treatments, including no medication.

Medical staff should ensure that parents or caregivers understand the explanation, have the capacity to give consent, and are not coerced or manipulated into giving permission. Verbal consent can typically suffice when a written signature cannot be obtained; however, a copy of the consent form and information about the medication should be mailed to parents. Most facilities require informed consent for the continuation of psychotropic medication prescribed in the community, although it typically does not have to be acquired immediately upon admission. Youth and their parents or caregivers should be involved in decisions associated with stopping psychotropic medication. Informed consent laws associated with psychotropic medication for incarcerated youth differ by state and locality; mental health and medical staff should familiarize themselves with local laws and be alert to any updates.

Suicide Prevention with Youth In Custody

Suicide is the leading cause of death among youth in confinement[39] and is more common among incarcerated youth than those in the community.[40] Death can seem like the only option to youth in custody who feel hopeless, alone, anxious, or depressed and who want to escape unbearable psychological pain, distressing circumstances, or dire futures. There are two types of staff that work directly with youth in custody: those who have encountered suicidal youth and those who will.
A study of youth in detention found one in ten had thought about killing themselves in the previous 6 months, and a little over one in ten had made an actual suicide attempt at some point in their lives, with many trying to kill themselves more than once. Fewer than half of the youth with recent suicidal thoughts had told anyone about them. Rates are likely even higher among youth who are deeper in the system—those who reside in longer-term juvenile justice facilities.

Who Is Most At Risk for Suicide?

When working with youth who have the risk factors below, line staff should be alert to the possibility of suicidal thoughts or behavior.

- Previous suicidal behavior.
- Mental Health Disorders (e.g., depression, bipolar).
- Substance use disorders.
- Aggressive or violent behavior.
- Family factors (e.g., suicide, mental illness, substance use among parents or caregivers; parental absence; lack of support; abuse or neglect; family conflict or domestic violence).
- Poor social skills or few friends.
- Stressful life events (e.g., legal or discipline problems; incarceration; isolation from peers in a facility; lengthy time in room or cell; prolonged stay in a juvenile justice facility; discipline or failure at school; break-up of romantic relationship; conflict with parent or other important adult; victim of bullying, harassment, humiliation, or rejection; sexual assault; death of a loved one; believing peers will harm or kill them).
- Childhood abuse or neglect.
- Exposure to someone else’s suicide.

Because most incarcerated youth often have three, four, or even all of the listed suicide risk factors, plus the stress of being detained or incarcerated, and restricted access to their typical coping skills (cigarettes, alcohol, other drugs, fighting, sex, running away)—all youth in custody should be viewed as at-risk for killing themselves.

The majority of youth who have died by suicide in juvenile justice facilities were not on any type of suicide precautions at the time of their death. Therefore, we need to be vigilant about suicide among all incarcerated and detained youth—at all times.

Youth in custody are commonly housed alone in rooms with door knobs, handles, large hinges, protrusions on the ceiling, vents, towel racks, bunk beds, toilets, floor drains, clothing hooks, and other secure items to which they can tie a sheet, t-shirt, bra, or torn blanket and asphyxiate themselves. Even toilet paper or plastic trashcan liners can be twisted or braided into strong enough material to strangle oneself. If youth want to die, they can jump off the second tier of a two-story unit, jump in front of a moving vehicle on campus, asphyxiate themselves with hair extensions, or suffocate themselves by putting plastic liners of trash cans over their heads. Despite safe and secure facilities, there is a multitude of ways confined youth can kill themselves.

Protecting Youth in Custody

The best way to prevent suicide in juvenile justice facilities is to prevent youth from becoming suicidal in the first place. Implementing the recommendations and strategies throughout this chapter (e.g., mental health and suicide-specific screening and assessment, developing positive relationships, meaningful programming, education and vocational programs, home-like environments, evidence-based mental health and suicide-specific psychotherapy, a trauma-responsive approach, parent or caregiver engagement, skill-building rather than punishment, strength-based behavior management, a variety of recreation and leisure activities, collaboration between juvenile justice, mental health, medical and education staff) is one of the best ways to reduce the chances that a youth in custody will try to take his or her own life.

Identifying Youth Who Want to Die

Even though most youth in custody are at increased risk for suicide, placing them all on “suicide precautions” or in suicide-resistant rooms is not only impractical and unrealistic, it would likely be psychologically harmful. It is also unnecessary, because, despite having multiple suicide risk factors, the majority of youth in custody do not try to kill themselves.

Currently, there is no failsafe way to predict exactly which youth will try to take their own lives; identifying who is the highest risk for suicide among an already high-risk population is challenging. There is no “typical” suicidal youth. They may 1) be sad and withdrawn, 2) state they want to die, 3) deny suicidal thoughts or intentions, or 4) be angry and aggressive. Therefore,
juvenile justice and mental health staff must consider multiple factors when determining degree of suicide risk, including observable behavior, youth history, facility suicide hazards, and youth interview.

**Observe Behavior**

Staff may not recognize depression among confined youth, as it is often experienced and exhibited as irritability, agitation, or aggression versus a sad mood; when these youth are mistakenly viewed as “bad” and given significant sanctions, their depression is likely to worsen. Suicide-related behavior has also been seen among intensely angry or frustrated youth, even though they are not depressed. All staff should be on the lookout for the following behaviors; exhibiting one of them does not necessarily indicate increased suicide risk, but a combination of them is concerning:

- Sad or depressed mood.
- Increased irritability or agitation.
- Reduced interest or pleasure in activities they used to enjoy.
- Complaints of having no energy or feeling tired all of the time.
- Excessive levels of guilt or shame.
- Difficulty concentrating or making decisions.
- No emotion or youth seems apathetic.
- Threatening or aggressive behavior.
- Restless or agitated behavior.
- Very slow speech or behavior.
- Lack of appetite or overeating.
- Problems falling or staying asleep, or sleeping too much.

**Youth History**

The more risk factors in a youth’s history, the higher his or her risk for suicide.

- Previous suicide attempt.
- Knowledge of or exposure to someone else’s suicide.
- Past psychiatric hospitalization.
- Prior or current psychotropic medication.
- Prior or current mental health disorder (e.g., depression or bipolar).
- Substance use disorder.
- Multiple traumas.
- Irritability or difficulty controlling their anger.
- Family history of mental illness.
- Violent behavior.

**Facility Suicide Hazards**

Potential facility suicide hazards include:

- Low number of staff per youth requiring supervision.
- Over-reliance on isolating juveniles.
- Easily reached protrusions or projections in rooms.
- Access to psychotropic medication.
- Unit or cottage layout.
- Clothing or uniforms with shoelaces, belts, or zippers.
- Access to toxic materials (e.g., shampoo, cleaning chemicals).
- Routine and predictable monitoring.

**Youth Interview**

All staff that work directly with youth in custody must be comfortable asking them about their suicidal thoughts and behavior. A five- to ten-minute private interview is usually enough time to determine whether juveniles are:

- Potentially suicidal.
- In need of referral to a QMHP.
Staff should approach youth they are concerned about, convey the specific behaviors that have them worried, and directly ask youth if they have been thinking about killing themselves. Staff should ask how youth would go about killing themselves if they report suicidal thoughts. Differentiating youth with passing thoughts from those seriously considering ending their lives is key. If youth describe a plan, staff should ask questions to assess 1) the specificity, 2) availability, and 3) lethality of the plan. Details, easy access, and plans that could result in death all increase a youth’s risk of suicide.

If time allows, staff should ask youth:

- If they have made a previous suicide attempt. If so, when and how, and if they were hospitalized.
- If they ever thought about suicide and did not make an attempt. If so, what they did to cope in that situation.
- If there is one thing would help them no longer feel suicidal.

Incarcerated youth may not feel comfortable sharing the details of their suicidal thoughts, feelings, or plans with staff; or they may not want staff to interfere with their plan to die. That said, most youth—particularly those in emotional pain—answer honestly when asked about suicidal thoughts and behavior when staff are calm, nonjudgmental, and genuinely caring. Maintaining a conversational tone is much more effective than running down a checklist of questions or treating the interview as an interrogation. Staff should trust their judgment and intuition and talk with a supervisor or QMHP if a youth denies suicidal thoughts, but staff remain concerned about them due to their history, observable behavior, or facility hazards. [43]

There is no way to tell if youth are manipulating or truly want to die; “manipulative” individuals have died by their own hands. Although frustrating and difficult to manage, youth who engage in suicidal behavior solely to solicit attention, facilitate a transfer, or obtain coveted resources can accidentally kill themselves; they should be taken seriously, referred to QMHPs for an evaluation, and be closely monitored. Many “manipulative” youth have underlying mental health, substance use, and trauma-related disorders, as well as other risk factors that raise their suicide risk.

Key Components of a Suicide Prevention Program for Youth in Custody

All juvenile detention, corrections, and adult facilities that house youth must develop and implement comprehensive suicide prevention programs to identify potentially suicidal youth and respond in ways that reduce their suicidal thoughts and behavior. The recommendations below are based on correctional health care standards,[44] though most go further and include best practices.

Policies and Procedures

- Suicide prevention policies and procedures should be written clearly, concisely, and in language easily understood by staff at all levels.

Suicide Prevention Training

- Upon hire, every facility staff who comes into contact with or makes key decisions about youth should receive mandatory, practical, up-to-date and interactive training on suicide prevention among youth in custody (8-16 hours); mandatory refresher training (2-4 hours) should occur annually.

Suicide Screening and Referral

- All youth in custody should be screened for suicide risk, in a private setting, by appropriately trained staff using a standardized form with interview questions and behavioral observations.
- Youth identified as potentially suicidal should be placed on suicide precautions and immediately referred to a QMHP for an in-depth suicide assessment.
- Youth should be re-screened for suicide risk at important transition points throughout the system (e.g., change in placement) and whenever indicated by a youth’s statements, behavior, or information coming from other sources.
- Youth who elicit staff concern related to suicide at any point during their stay should be immediately referred to a QMHP for an in-depth suicide assessment. QMHPs should conduct a face-to-face suicide assessment of youth as soon as possible, but no longer than 24 hours after being contacted. Youth deemed to be a potential high risk for suicide should be continuously observed and monitored while awaiting a clinician’s evaluation.

Suicide Assessment or Evaluation

- QMHPs should be available on site or by telephone, 24 hours a day, seven days a week.
Suicide assessments conducted by QMHPs should determine a youth's degree of suicide risk, the level of monitoring needed, specific components for a safety plan, and if transfer to a psychiatric hospital is necessary. QMHPs have the license, education, training, and experience to make these decisions.

A determination of suicide risk should take into account a youth's current behavior, history, and issues specific to the facility, in addition to the youth's statements. Parents or caregivers may be able to provide valuable information related to a youth's risk of suicide, as well as helpful strategies to support him or her. Youth placed on suicide precautions should be re-assessed in person (not through a door) by a QMHP at least once per day to determine if their suicide status has changed and, if it has, the QMHP takes action to address it (e.g., increase or decrease in the required level of monitoring, transfer to psychiatric hospital, removal from suicide precautions).

Each day, QMHPs should gather information about a suicidal youth's behavior from a variety of staff with whom youth have interacted.

The period following removal from suicide precautions is a high-risk time for some juveniles; therefore, QMHPs should remain in close contact with youth after precautions end, assessing for suicide risk over the next several days. Contact should then be slowly spaced out, with QMHPs periodically assessing suicide risk.

Self-injury (cutting, head banging) is distinguished from suicide in screening, assessment and treatment, yet it is still regarded as a significant risk factor for suicide.

Intensive Monitoring

- Staff should monitor youth at high risk for suicide in person and on an irregular schedule not to exceed 5 or 10 minutes, depending on a youth's level of risk.
- Staff should “continuously” observe (1:1 youth-to-staff ratio, sight and sound, close proximity) actively suicidal youth (threatening or engaging in suicide-related behavior) or transfer them to the hospital.
- Staff should clearly document all monitoring.
- Closed-circuit television and other ways of supervising suicidal youth can supplement, but never replace, in-person staff monitoring.
- Juvenile justice, mental health, and medical professionals should be adequately trained to place potentially suicidal youth on suicide precautions; only QMHPs should be able to lower or take youth off suicide precautions.

Safe Housing of Suicidal Youth

- Suicidal juveniles should be housed in the least-restrictive manner possible, given the severity of their suicidal behavior.
- Suicidal youth who can safely participate in standard facility programming should do so with more intensive levels of supervision, monitoring, and documentation. Staff should encourage youth participation.
- Suicidal youth should have access to the same academic, recreation, and leisure opportunities as their peers, unless these are modified for safety purposes; only QMHPs can implement or remove these modifications, and they must be documented and communicated to all relevant staff.
- Suicidal youth should not be isolated; if this must be done for safety reasons, the decision should be made in collaboration with a QMHP, and suicidal youth must be continuously monitored.
• Social interaction is essential to suicide prevention; removing suicidal youth from peers and programming can add to their feelings of alienation and depression. When alone in a cold and empty room, suicidal youth have little to distract them from their problems and a great deal of time to think about ways to kill themselves.

• Suicidal youth who are unable to remain on their own living unit can be housed in safe rooms on mental health units or a health clinic. Youth should be housed near staff stations, with staff regularly interacting with them.

• Suicidal youth should remain in regular clothing (except if wearing shoelaces or belts), unless they use their clothing to harm themselves. In those instances, only that piece of clothing should be removed.

• Safety smocks should not be used, except in rare circumstances where it is indisputably necessary for youth safety and is done in collaboration with a QMHP. Youth should never be made to wear special clothing that signifies their risk of suicide. All rooms or cells that house suicidal juveniles should be suicide resistant (e.g., no secure objects youth can tie something to and asphyxiate themselves, nothing youth can use to suffocate themselves, large viewing windows)

Every facility should have enough suicide resistant rooms to meet the needs of their population.

Communication About Suicidal Youth

• Juvenile justice, mental health, medical, and educational staff should meet daily to discuss which youth in the facility are on suicide precautions and the most effective strategies to observe and manage them.

• Juvenile justice staff should communicate from one shift to another about 1) which youth are on suicide precautions, 2) the level of intensive monitoring required, and 3) any specific information needed to help keep these youth safe.

• Communication about suicidal youth should occur between facility staff and community agencies (e.g., arresting or transporting officer, local court, psychiatric or medical hospitals) when necessary.

• QMHPs should communicate with juvenile justice and medical staff before removing youth from suicide precautions.

• Juvenile justice, mental health, and medical staff should document essential information related to which juveniles require more intensive monitoring and why. Documented information from a variety of sources helps juvenile justice staff strategically manage suicidal youth and helps QMHPs evaluate and develop intervention strategies for them. Staff should document factual information (e.g., what staff observed, heard, read) and avoid statements about motivation (e.g., trying to get attention). Behavioral observations related to depressed mood, irritability, or aggression should also be recorded.

Responding to an Active Suicide Attempt

• Staff must know how to respond to suicide attempts in progress, especially hangings and other forms of asphyxiation, and should be trained in providing first-aid, CPR, and other life-saving measures.

• Realistic suicide-intervention drills should be conducted randomly and regularly to help staff practice life-saving strategies in situations where errors could have tragic results.

• Suicide cut down tools (see Figure A) should be located on every unit, easily accessible to staff, and inventoried every shift.

• Staff who discover a youth attempting suicide should immediately respond, assess the severity of the emergency, alert other staff to call for medical personnel if needed, and begin life-saving measures.[45]

Staff should never assume youth are dead and should do all they can to keep youth alive until medical professionals take over.[46]

Reporting and Notification of Suicidal Behavior

• Policies and procedures should be in place for staff to easily document which youth have been identified as a high suicide risk. Staff should use standardized forms to document close observations and intensive monitoring of suicidal youth. Forms should be easy to understand and easy to complete. Staff should follow documentation procedures in the event of a completed suicide.

• QMHPs should inform parents or caregivers if their child is placed on suicide precautions and inquire about strategies that have previously decreased the youth’s distress.

• Staff should notify administrators and outside authorities about potential, attempted, and completed suicides, according to policy. If youth are a high risk for suicide close to the time they are returning to the community, staff should enlist the support of parents or caregivers and community mental health providers with regard to continued assessment, monitoring, and treatment.

• When recently or currently suicidal youth are released, QMHPs should educate parents or caregivers about the danger of guns and other potentially lethal means in the home and encourage them to remove these items.

Review and Debriefing

• If a tragedy such as a serious suicide attempt or completed suicide occurs, several types of reviews should take place (e.g., administrative, mental health, medical) to better understand exactly what happened, why, and what necessary
improvement measures are required, if any. The goal is to gain information and to learn, not to find someone to blame.

- A psychological autopsy should be conducted within 30 days of a completed suicide by a psychologist or psychiatrist to better understand the specific factors that may have contributed to a youth taking his or her own life.
- A quality-assurance process should be in place to monitor the components of a facility’s suicide prevention program, with immediate modifications made when indicated.
- A debriefing (e.g., structured group process to help individuals effectively cope in response to a traumatic loss) should be made available as soon as possible (preferably 24 hours, no longer than 72 hours) after an incident to all staff and youth who may have been impacted by a serious suicide attempt or completed suicide. Staff involved in the incident should not be mandated to immediately return to job duties.
- Youth should be encouraged to talk with a QMHP about any thoughts and feelings they have in relation to a peer's suicide or suicide attempt.
- Staff should be encouraged to seek additional support through the Employee Assistance Program (EAP) or other sources, if needed.

After a Serious Attempt or Completed Suicide

It can be traumatic and painful to work with youth who have made serious suicide attempts or who have died by suicide. Many line staff have intervened with youth they have found hanging or strangling themselves, as well as youth who have seriously cut their wrists or other body parts. Some staff have performed life-saving procedures in situations where youth still died, despite their efforts. Staff are often required to return to work immediately after these types of disturbing incidents to supervise the rest of the other youth on a unit. This should never happen.

Youth are often upset and confused when another resident makes a serious suicide attempt or dies by suicide. This is a particularly high-risk period for other youth in custody to take their own lives; therefore, staff should be vigilant to signs of distress, especially among vulnerable youth.

Intense guilt is common among staff who were unable to prevent a juvenile suicide. They may wonder if they overlooked key warning signs or what would have happened if they had checked on the youth a few moments earlier. Some staff feel guilty when youth kill themselves on a day when they were not present, believing that they may have been able to prevent it had they been on duty.

Working with suicidal youth can have significant emotional and psychological effects on direct care staff. These effects are intensified when staff work with multiple suicidal juveniles throughout their career. Investigations and litigation after a death by suicide can add to already disturbing, stressful, and traumatic situations. Unless there was significant wrongdoing, staff should be given support and patience if they have been involved with seriously suicidal youth.

Self-Injury Among Youth in Custody

Although known by various names—self-injury, self-mutilation, cutting—this type of behavior reflects a youth’s deliberate harming of his or her own body as an attempt to feel better. It affects boys and girls of all racial backgrounds. Self-injury creates a safety risk and is disruptive to the facility environment. Although suicide training is mandatory, most staff receive little to no training in the identification and management of juveniles who self-injure.

Youth intentionally harm themselves most commonly on the forearm, but they can injure anywhere on their bodies, including areas covered by their undergarments. Superficial cuts or scars do not necessarily indicate less distress; all self-injury should be taken seriously.

Self-Injury Versus Suicide

Self-injury and suicide are two very different behaviors. Suicide is related to death, whereas self-injurers often report their harm makes them feel alive and helps them live. Many youth who self-injure report that if they could not hurt themselves, they would be overwhelmed, unable to cope, and potentially suicidal. They usually know where and how deep to cut so they do not accidentally die. Two distinct behaviors—self-injury and suicide—can occur simultaneously, and engaging in self-injury raises a youth’s risk of suicide.[47] When they occur together, the desire to die may resolve once a suicidal crisis is over, but juveniles are likely to continue injuring themselves to cope with everyday emotions and stress.

Items Youth Use to Hurt Themselves

Despite careful and frequent room searches, watchful staff, and minimal access to sharp objects, youth who self-injure can always find ways to hurt themselves. The following items have been used by juveniles in custody:
• Staples, paper clips, thumbtacks.
• Pencils, pens.
• Combs, brushes.
• Eye glasses.
• Teeth, fingernails.
• Forks, knives, broken plastic spoons.
• Snaps, zippers, belt buckles.
• Rocks or gravel.
• Broken DVDs, playing cards.
• Paint chips, pieces of floor tile.
• Pull tops from pop can.
• Metal clasps on ace bandages.
• Dried peach pits, apple cores, orange peels, or chicken bones.

Cutting, scratching, and carving their skin are the most common ways youth in custody deliberately harm themselves, however some punch themselves, punch walls, bite themselves, pull out their hair, bang their heads against doors, give themselves eraser burns, or interfere with the healing of scabs or wounds.

Some incarcerated youth have engaged in dangerous and severe self-harm—ripped out medical stitches, inserted pens into healing wounds, held drain cleaner in their mouth “to feel the burn,” and inserted pens into their penis. This type of self-injurer typically begins with superficial wounding and needs to make deeper and larger cuts or experience more intense levels of pain to achieve their desired level of release.

Why Do Youth Hurt Themselves?

Self-injury is typically a coping strategy used during times of stress or intense, overwhelming feelings. Hurting themselves helps youth 1) regulate or control their emotions, 2) reduce stress and tension, or 3) get their emotional or relationship needs met. Some youth communicate through self-harm what they cannot say in words; others hurt their bodies in custody because it is something they can control. Although usually driven by emotional reasons at the start, a youth may continue to self-injure because of responses or reactions that the behavior elicits from others (e.g., attention, support, exemption from responsibilities, shocking staff or peers, transfer). For the small group of youth who harm their bodies solely as a strategy to solicit attention, their behavior should still be taken seriously, and they should be referred to a QMHP for evaluation.

Managing Youth in Custody who Self-Injure

Self-injury is typically a symptom of a larger problem; a comprehensive mental health assessment is necessary to identify any psychological issues or disorders and determine what function the behavior serves in the context of the unit. Clinicians should develop individual treatment plans, use evidence-based therapy, and help staff reinforce youth for not engaging in self-harm and for using appropriate coping skills. Staff from all disciplines should provide emotional support and attention before youth self-injure. Unit schedules and staff teams should remain as consistent as possible, and staff should inform youth of any upcoming changes in the routine. Staff should provide extra support during major transitions (e.g., new unit or staff, transfer, release), as these can be high-risk periods for self-harm.

Housing and monitoring decisions should be based on findings from the mental health assessment. Unless their self-injury is severe, most youth can participate in standard facility programming with minor modifications; when programmed, they have little time to think about self-injury—and even less time to do it. Youth may lose certain privileges related to using specific items or participating in certain activities if they are unable to keep themselves safe with those items or activities. In these situations, staff should emphasize safety and security rather than present restrictions as punishment. As soon as youth demonstrate signs of safety, staff should strategically lift restrictions. Secluding or isolating youth who self-injure should be a response of last resort. Removing youth from peers and programming often worsens their distress and intensifies their need to hurt themselves. Plus, youth can still bang their heads, as well as bite or scratch themselves while isolated. Regardless of where youth are housed, staff should be stationed near self-injurious youth and regularly interact with them. This is not suicidal behavior, therefore if intensive monitoring is required, it should be referred to as “safety precautions” or “safety watch.” Facilities without the resources to safely manage severely self-injuring youth should transfer them to a psychiatric hospital or residential treatment facility.

Staff Responses to Youth Who Self-Injure

Feeling frightened or disgusted by self-injury is a natural reaction, especially when wounds are bloody or located on certain parts of the body. Staff should maintain a matter-of-fact attitude and tone when dealing with self-injury; these youth are
often ashamed of their behavior and know that it is unusual and strange. If staff appear uncomfortable, upset, or grossed out by injuries or scars, youth will be less likely to talk to them about underlying thoughts and feelings and will keep wounds a secret.

Staff should convey:

- An understanding that self-injury helps some youth cope.
- They do not view self-injurious juveniles as crazy or weird.
- Youth will need to stop hurting themselves in the facility due to safety and security issues.

This approach shows respect for youth, especially when staff communicate their commitment to keeping youth safe and supporting them in learning more acceptable ways of dealing with strong emotions, stressful situations, and challenging personal relationships.

**The Move Toward Trauma-Responsive Care**

Since the inception of juvenile justice system, the philosophy of how best to respond to delinquent youth has swung back and forth between rehabilitation and punishment. Recently, there have been three major approaches used with youth in custody; each has potential benefits for youth in custody with mental health disorders, as well as potential drawbacks or even harm. Some facilities primarily rely on one approach; others have integrated aspects of two or three. Even within a particular facility, the approach may differ, depending on the unit, the shift, the specific staff, and the individual youth being supervised. **Youth benefit most when these three approaches are used together in a strategically balanced and integrated manner.**

The following are general descriptions; they are much broader and deeper in actual practice.

**Juvenile Corrections Approach**

In a juvenile corrections approach, youth are typically seen as intentionally engaging in negative behavior in the facility and community to obtain something for themselves (e.g., power, status, material goods, attention); youth need to “make better choices.” Safety, structure, predictability, and accountability are central to all management strategies. These issues are essential for youth who have mental health disorders; youth will not truly engage in treatment if they do not feel safe. The emphasis on clear and specific behavioral expectations and strength-based behavior management programs is also important for youth success.

Unfortunately, sanctions may be often issued without exploring whether there are potential vulnerabilities or alternative explanations for a youth’s behavior. For example, aggression receives the same penalty whether it is exhibited by a sophisticated gang member carrying out a hit, a traumatized youth trying to protect himself or herself from a perceived attack, or an intellectually disabled youth responding out of intense frustration. This approach encompasses the belief that the discomfort and distress of incarceration and sanctions (e.g., loss of privileges, room confinement) is what motivates youth to engage in pro-social behavior in the future. However, no data exist to support that assumption. Also, some types of responses to negative behavior within this approach (particularly those that are confrontational, harsh, or punitive) can actually escalate the anger, aggression, destructive behavior, or withdrawal of confined youth with mental health, substance use, co-occurring, and trauma-related conditions.

**Treatment-Oriented Approach**

In a more treatment-oriented approach, youth in custody are typically viewed as having deficits that need to be fixed or treated. The negative behavior of youth is usually seen as related to a mental health or substance use disorder, criminogenic needs, or other underlying issues. According to this approach, if those problems were treated, a youth’s negative, delinquent, or violent behaviors would diminish or completely stop. Accountability remains, but there tends to be more emphasis on comprehensive assessments, individualized treatment plans, and cognitive-behavioral, skill-based therapy to help youth better manage their thoughts and behavior. Youth typically receive mental health, substance use, or co-occurring disorder diagnoses; and many receive psychotropic medication. This approach can be very beneficial when diagnoses are accurate and treatment plans (and the associated treatment provided) target a youth’s key issues. Unfortunately, youth in custody are frequently over-, under-, and misdiagnosed, QMHPs are lacking in many skills, and there can be minimal collaboration between juvenile justice and mental health staff; these issues can lead to inappropriate treatment or treatment that can worsen a youth’s thinking, moods, or behavior.
A third and more recent approach for youth in custody, is one that is trauma responsive. The assumption is that negative behavior within facilities is not always intentional, but more likely the result of traumatized youth being triggered and overreacting to what they perceive to be a threat.[48] Accountability remains key in a trauma-responsive approach, and youth continue to receive comprehensive assessments and individualized treatment plans, and are taught skills to better manage their thoughts and behavior. However, differences include:

- An increased focus on traumatic events and trauma-related symptoms during screening and assessment.
- No mental health diagnoses given to juveniles until clinicians first address the impact of trauma.[49]
- Symptoms are seen primarily as attempts to cope and survive.
- Psychotropic medication, if used, is not the first line of treatment.
- All staff use a strength-based approach with youth.
- Negative behaviors do not necessarily stem from something inside youth (e.g., depression, ADHD, bipolar), but often from youth reacting to events outside themselves.
- Emphasizes the reduction of trauma triggers in the environment and provides safe places (e.g., comfort room) and tools youth can use to practice self-calming skills.[50]
- Takes into account research on how trauma negatively impacts the brain.
- Emphasizes key relationships between youth and supportive adults, such as line staff.

With this approach, youth are not to blame for their victimization and traumatic experiences, but are responsible for learning how to effectively cope and manage their emotions and behavior when their trauma response is triggered. Adults in the facility help youth 1) recognize how they have been impacted by trauma, 2) identify what specifically triggers their trauma-related reactions (e.g., angry outbursts, shutting down, aggression, overreacting, self-injury), and 3) learn more appropriate ways to respond.

Challenges of this approach include the need for significant training, on-the-floor staff coaching, and changes to existing policies and procedures. When management strategies such as isolation and restraint are discouraged, due to potentially re-traumatizing youth, staff may initially feel powerless and unsafe. They may also perceive this approach as excusing negative and dangerous behavior.

Trauma-Responsive Care with Youth in Custody

In trauma-responsive care, conversations shift from “What’s wrong with you?” to “What happened to you?” and “What’s right with you?” Staff interactions with youth focus on “What do you need?” and “How can we support you?”

For example:

Kevin, 15, is repeatedly removed from the classroom for hostile behavior toward the teacher and sent back to his living unit. When placed in his room, he becomes increasingly angry and agitated, kicks the door, and yells provocative comments to staff. When peers return to the unit, he verbally and physically intimidates and threatens some of the smaller and younger boys. It is discovered that Kevin has struggled in school for years due to attention and memory problems. When his teacher in the facility demands he turn in his written assignments before he has finished them, Kevin blows up in anger due to the belief that “this teacher wants me to look stupid and is trying to embarrass me” just like all the other ones. Alone in his room, Kevin is consumed with humiliation, shame, and feeling “stupid,” so he distracts himself by engaging staff which is ineffective. To regain a sense of control, empowerment, and success, Kevin terrorizes peers who are more vulnerable than himself.

From a juvenile corrections approach, Kevin would likely receive a variety of sanctions each day his negative behavior occurred. This cycle could continue for days, weeks, or longer—with little to no new learning or change in behavior. From a treatment approach, in addition to cognitive-behavioral group therapy for his criminogenic needs, Kevin may be diagnosed with a learning disorder, ADHD, or depression; he may receive therapy (and possibly psychotropic medication) to treat it. Unfortunately, if he were diagnosed solely with conduct disorder, treatment would be minimal.

With a trauma-responsive approach, Kevin would receive consequences for his negative behavior, plus, he and staff would work together to 1) identify and understand what triggers his reactions and negative behavior and 2) practice new and more appropriate responses when triggered.[51] Safety and self-regulation are key. Staff help youth learn to better control their thoughts and behavior (sometimes in the moment, as problematic behavior is occurring) instead of automatically and reflexively responding in disruptive and sometimes dangerous ways.[52]

A trauma-responsive approach is likely to be effective with most, if not all, youth in custody because of their high rates of multiple types of trauma. It is also likely to be effective with youth who have mental health, substance use, and co-occurring
disorders because:

- Trauma increases a youth’s risk of developing mental health disorders, so youth often have both conditions.
- Many mental health symptoms overlap with trauma-related symptoms.
- Some trauma-related symptoms are misdiagnosed as mental health symptoms.
- Many youth in custody use alcohol or other drugs in response to trauma-related symptoms.

A trauma-responsive approach works well with the treatment approach. Rather than staff exerting control over youth, in both treatment and trauma-responsive approaches, the emphasis is on staff helping youth gain better control over themselves. A key modification is that the impact of trauma on a youth’s mood and behavior is taken into account before youth are viewed as having antisocial attitudes, labeled with mental health or substance use disorders, or prescribed psychotropic medication.

Child-serving systems across the country are moving toward a trauma-responsive model of care, including Florida’s Department of Juvenile Justice (DJJ) and New York’s Office of Child and Family Services (OCFS).

Discovering that a youth experienced a traumatic event at some point in his or her life should not automatically trigger a mental health referral. Facilities do not have the resources to provide treatment to every youth who has experienced trauma, and not every one of them needs it. However, youth should be referred if he or she is currently experiencing trauma-related symptoms and is distressed by trauma-related symptoms, or if trauma-related symptoms interfere with the youth’s ability to do well in school, on the living unit, or in relationships.

**Effective Treatment Strategies for Youth in Custody with Mental Health, Substance Use, Co-Occurring, and Trauma-Related Needs**

In addition to the recommendations made throughout this chapter, best practices in the treatment of incarcerated youth with mental health, substance use, co-occurring, or trauma-related needs also include:

**The Basics**

- Youth feel physically safe (e.g., in the physical structure, with peers, with staff, with themselves if they have a history of self-injury or suicidal behavior). Sufficient numbers of qualified juvenile justice, mental health, and medical staff are available to address youth safety, programming, and treatment needs.
- Structure, consistency, and predictability are emphasized in all programming and treatment activities; youth receive ample warning about staff and program changes.
- Staff recognize that youth with mental health disorders are a heterogeneous and resilient group, each possessing different needs, strengths, and challenges.
- Clear and easy-to-understand rules, expectations, and directions are verbally explained to youth and are written down.
- Units are more home-like (e.g., youth art on walls, colored walls, carpet or rugs, comfortable furniture, holiday decorations) than correctional or institutional in look and feel.
- Treatment providers recognize that youth and their parents or caregivers are in various stages of change, assess what stage they are in, engage them, and match treatment to their current stage of recovery.[53]

**Formal Mental Health Treatment**

- Staff realize that mental health treatment is often an ongoing, long-term process; relapse is common and should be planned for.
- Mental health professionals focus on developing and strengthening protective factors, rather than solely reducing mental health symptoms.
- Individualized treatment plans address specific short- and long-term goals in multiple key areas of a youth’s life, especially for those who exhibit significant mental health symptoms or dangerous, disruptive, or aggressive behavior.
- Treatment for co-occurring mental health and substance use disorders is integrated and provided by the same treatment provider or by a team of providers who closely communicate and take equal responsibility for intervention goals.
- Staff ensure that all cognitive-behavioral treatment is appropriate for a youth’s intellectual and developmental level.
- Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings are available within the facility and are modified for adolescents.

**Involvement of Line Staff**
• Staff are alert to unusual youth behaviors, moods, or statements of concern and refer youth to mental health staff for follow-up.
• Staff are alert to physical complaints (e.g., headaches, stomachaches, fatigue, vague muscle or joint pain, multiple requests to see the nurse or doctor), take them seriously, and communicate them to medical personnel to determine if they are associated with depression, anxiety, trauma, or physical illness.
• Staff understand that some youth require accommodations or adjustments in programming to be successful in the facility.
• Staff actively engage youth and develop trusting and empathic relationships. This type of connection is essential to creating positive treatment outcomes among youth with mental health, substance abuse, co-occurring, or trauma-related symptoms.
• Staff recognize that taking time up front to understand youth and their individual needs, strengths, and limitations saves them time and energy in the future (e.g., increased compliance, fewer power struggles, fewer sanctions).
• As key members of the treatment team, line staff participate in mental health treatment planning. Line staff perceive themselves as central to the treatment process, as do youth and other professionals throughout the facility.

Brain-Related Treatment Issues

In addition to the aforementioned strategies, the following recommendations should be used in the treatment and day-to-day management of youth with brain-related issues:

• Treatment professionals utilize current brain research to better understand normal adolescent development, trauma, criminal behavior, and aggression; relevant concepts are communicated to juvenile justice and education professionals.
• Staff hold realistic expectations of youth with cognitive disabilities (including those with suspected or confirmed head injuries or brain damage).
• Staff speak in clear, short sentences, and provide youth with additional reminders, structure, and supervision, when needed.
• Because a youth’s response to medication can be affected, professionals who prescribe psychotropic medication investigate the possibility of head injury or brain damage.

Youth who have suffered head injuries or trauma-related brain changes need interventions that focus on:

• Thinking before acting.
• Managing anger.
• Decreasing or discontinuing substance use.
• Interacting with others in a pro-social manner.
• Reducing stress.
• Correctly perceiving social cues (versus suspicious misperceptions).
• Empathizing with others, especially victims.

Threats of sanctions or punishment do little to modify the behavior of youth with head injuries or brain damage due to their difficulty conceptualizing abstract and future events or consequences.

Trauma-Related Treatment Issues

In addition to the aforementioned strategies, the following recommendations should be used in the treatment and day-to-day management of youth with trauma-related needs (whether or not they are diagnosed with PTSD):

• Trauma training (e.g., understanding the impact of trauma on thoughts, behavior, and the brain; trauma-responsive management strategies) is provided to all facility staff. Clinical training on trauma-responsive treatment is provided to all treatment providers.
• Past traumatic events are discussed to better understand and modify current problematic behavior and positively influence future behavior—not to dwell on past pain or victimization.
• Interdisciplinary treatment teams integrate the impact of trauma into case conceptualizations of youth, individualized treatment plans, interventions, and daily programming. Neutral or strength-based words are used in place of “victim” when talking directly with youth about their past.
• Youth are educated about the effects of trauma on their thoughts, emotions, behavior, and brain; youth are reassured they are not going crazy.
• Staff listen and provide support to youth, help them de-escalate when youth are upset, and assist them in developing more adaptive thoughts and behaviors when triggered by people or situations.
• Staff exhibit patience, creativity, and flexibility in their management and programming of trauma-affected youth.
- Youth learn practical coping skills to help them manage feelings of anger, shame, guilt, embarrassment, or fear.
- Staff are diligent about their role as mandated reporters of child abuse and neglect and clearly explain to youth what information remains confidential (if any), what can be released and under which specific circumstances, and who will likely receive information if a report must be made.
- Evidence-based, gender-specific treatment for trauma, including sexual abuse, is available for girls and boys.
- Staff assess their own comfort level when youth talk with them about trauma; if uncomfortable, they refer youth to other supportive and trusted professionals in the facility.
- Due to the demanding, stressful, and potentially traumatic nature of working with incarcerated youth, staff use good self-care strategies on the job and in their personal lives. They obtain support (e.g., Employee Assistance Program, community resources) for any unresolved trauma from their own past, so as not to be triggered by a youth’s aggressive, destructive, or disturbing behaviors—or the correctional environment itself.

See *Juvenile Offenders with Mental Health Disorders: Who Are They and What Do We Do with Them* for management strategies specific to youth in custody with conduct disorder, ADHD, depression, bipolar, PTSD, learning disorders, fetal alcohol syndrome, self-injury, and other mental health conditions.[54]

**Foundational Treatment Strategies**

Effective behavior management, physical activity, and good nutrition are the foundation of effective treatment for youth with mental health, substance use, co-occurring, and trauma-related conditions.

**Effective Behavior Management**

Key principles of effective behavior management in custody include:

- Caring staff who model pro-social behavior and coping skills.
- Structured programs and meaningful activities with clear expectations for youth.
- Behavioral consistency among staff on all shifts.
- Frequent reinforcement of youth success, no matter how small. A minimum of four reinforcers for every one punishment.[55]
- A well-designed, easy-to-understand, easy-to-implement, and effective strength-based token-economy system.
- Sanctions or negative consequences match the level and type of youth misbehavior.
- Staff recognition of how difficult it is for youth to modify numerous key behaviors at the same time (e.g., attend school, control emotions, control behavior, develop new social skills, stop using profanity, participate in treatment), while simultaneously discontinuing their typical coping skills (e.g., intimidation, aggression, social withdrawal, alcohol or other drugs, running away).[56] See Ch. 14: Behavior Management[56]

**Physical Activity**

Vigorous exercise can enhance self-esteem, decrease depression, reduce anxiety and tension, and help youth sleep better.[56] Exercise changes chemicals in the brain, including those associated with mood-related disorders. Providing youth in custody with a variety of opportunities to be active and participate in outdoor recreational activities gives them a chance to demonstrate success in pro-social activities and burn off high levels of energy. Team sports help youth resolve conflict without intimidation and aggression and engage in healthy competition. Individual recreation activities should also be available, as some youth are self-conscious about their coordination or skill level.

Yoga helps reduce stress, and decreases depression and anxiety.[57] It appears to impact the fight or flight mechanism (commonly affected among youth with trauma histories). Yoga may be as effective as exercise, or even more so, for reducing fatigue and aiding sleep.[58]

**Good Nutrition**

What youth eat and drink impacts their mental health.[59] Nutrients affect areas of the brain that regulate mood and behavior, including the cerebral cortex. Providing youth in custody with healthier foods, less sugar, and more nutrients appears to help them better control their behavior.[60] Providing a vitamin-mineral supplement and essential fatty acid supplements reduced violence among incarcerated juveniles and young adults.[61]
Brief, practical, evidence-based psychotherapy can be provided to youth in short-term facilities, with more intensive psychotherapy provided in the community upon release. Youth in long-term facilities, or residing in detention or jail for lengthy periods, should receive more comprehensive evidence-based psychotherapy in custody, plus transition services upon return to the community. Regardless of the facility type or length of stay in custody, staff should encourage parent or caregiver involvement in psychotherapy.

Research on effective psychotherapy for youth in custody with mental health, substance abuse, co-occurring, and trauma-related needs (especially those who are aggressive and violent), is significantly lacking and desperately needed. The following treatments have shown beneficial effects for justice-involved youth, although most have primarily been used in the community. Some of these therapy approaches have been researched and evaluated; others are promising and need further evaluation.

- Cognitive Behavioral Therapy (CBT)[62] Most evidence-based therapy has cognitive-behavioral therapy at the core.
- Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET)[63]
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)[64]
- Dialectical Behavior Therapy (DBT) and DBT Corrections Modified (DBT-CM)[65]
- Aggression Replacement Training (ART)[66]
- Functional Family Therapy (FFT)[67]
- Trauma-Focused CBT (TF-CBT)[68]
- Trauma Grief Component Therapy-Adolescent (TGCT-A)[69]
- Trauma Recovery & Empowerment Model for Girls (G-TREM)[70]
- Eye Movement Desensitization and Reprocessing (EMDR)[71]
- Seeking Safety[72]
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)[73]

Multisystemic Therapy (MST)[74] and Wraparound Services[75] are community-based interventions that can be used in lieu of incarceration for some youth. Regarding youth in custody, community approaches are most appropriate for those who are briefly incarcerated. Youth housed for lengthy periods should receive treatment while confined, but can benefit from community-based interventions upon release. [See Ch. 10: Effective Programs and Services][76]

Individual treatment sessions can range from 20 to 60 minutes, depending on a youth’s attention span and level of engagement.

Group treatment is the norm within most juvenile justice facilities. Treatment groups tend to be most effective 1) with a smaller number of participants, 2) with a 45- to 60-minute maximum, 3) when led by individuals who have experience working with justice-involved youth and experience running treatment groups, and 4) when led by professionals who want to lead them.

Although the aforementioned therapy approaches may benefit incarcerated youth with mental health, substance use, co-occurring, and trauma-related conditions, maintaining treatment gains once formal treatment ends remains a challenge. The goal is for youth to function more effectively in a variety of situations and contexts—not just while they are in custody. Emotional and behavioral change within facilities is no guarantee of continued change in the community. Despite clinically sound treatment principles and programs, generalizing what youth learn in secure settings to their real-world circumstances is difficult unless treatment continues within their natural home environment after release. [See Ch. 18: Transition Planning and Reentry][77]

**Key Treatment Issues**

**Qualified Mental Health Professionals (QMHPs)**

According to NCCHC, QMHPs include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who—by virtue of their education, credentials, and experience—are permitted by law to evaluate and care for the mental health needs of patients.[76] However, qualified is essential; an advanced degree does not ensure the specific knowledge or clinical skills necessary to work with incarcerated youth, one of the most clinically complex and challenging groups of young people.

Within facilities, QMHPs should play a key role in:

- Mental health assessments (and screening when necessary).


• Crisis intervention.
• Individual counseling.
• Treatment groups.
• Staff training.
• Psychotropic medication.
• Individualized treatment plans.
• The placement of youth on or removing youth off of intensive monitoring (e.g., suicide watch, safety watch).
• Treatment programming.
• Screening mentally ill youth prior to placement in isolation.
• Assessing the effects of potentially traumatizing experiences (e.g., isolation, witnessing peers’ self-injury or suicide attempts).

Strategic and creative hiring of QMHPs is often necessary, because many clinicians are too intimidated or frightened to work with incarcerated youth; rural facilities may struggle to find eligible applicants due to limited QMHPs in the community. Facilities that struggle to find qualified applicants have had success advertising nationally, sharing a position with the local jail, choosing professionals early in their career or shortly after retirement, or finding professionals looking to supplement a private practice. Hiring unqualified mental health professionals can result in a pattern of misdiagnosis and inappropriate treatment, both of which can escalate a youth’s suffering, create an unsafe environment, and expose facilities to liability issues.

QMHPs should have knowledge, training, and experience with youth who have a broad range of emotional and behavioral disorders, as well as key issues related to:

• Normal adolescent development.
• Interactive effects of mental illness and substance use.
• Impact of trauma, including multiple interpersonal traumas.
• Cognitive, emotional, behavioral, and lifestyle issues common among incarcerated youth.
• Best practices for screening and assessing youth in custody.
• Evidence-based interventions or best practices for justice-involved youth who have mental health, substance use, co-occurring, and trauma-related symptoms.

If currently employed QMHPs need additional training, facilities should ensure they receive it.

QMHPs hired to work in facilities must be willing to collaborate with juvenile justice, medical, and educational professionals and use terms and concepts easily understood by youth and non-clinical staff. They must also understand the strengths and limitations of a youth’s self-report; many youth in custody are savvy about the mental health system, knowing precisely what to say to receive a prescription of psychotropic medication, facilitate admission to a psychiatric hospital, or avoid mental health treatment.

Psychiatric Hospitalization

Facilities vary considerably regarding their 1) physical design, 2) quantity and quality of mental health resources, and 3) provision of mental health treatment and programming. Many large and resource-rich facilities can manage youth with significant mental health needs, whereas others can manage youth with low to moderate mental health needs, but must transfer those with serious symptoms or disorders.

Most facilities, if not all, may need to transfer severely and acutely mentally ill youth (e.g., psychotic, imminently suicidal, manic, seriously self-injurious) to a psychiatric hospital or emergency room. Most facilities are not designed for—nor are they adequately equipped—to manage these youth or those with serious and chronic psychiatric disorders that require intensive, long-term treatment.

Hospitalization can stabilize youth and keep them safe during a crisis, but long-term behavior change is unlikely. Current lengths of stay in most psychiatric hospitals range from several days to several weeks, which is not enough time to treat complex mental health conditions.

Well before a crisis occurs, written agreements should be in place with all hospitals that may be used during an emergency. All parties should be clear regarding what entity has authority or responsibility for youth and who pays for hospital services. Criteria for a youth’s admission and discharge from a hospital should be explicit, and behavior that automatically results in a youth’s expulsion from a hospital also must be made clear.
Youth should not be released from a hospital without 1) a summary of what occurred during hospitalization, 2) a detailed discharge plan, and 3) thorough verbal communication with a QMHP and juvenile justice administrator at the facility.

Confidentiality

Administrators and mental health professionals must know federal and state laws and statutes that govern confidentiality and the release of mental health information in juvenile detention, corrections, and adult jails and prisons. Often, mental health information can be disclosed without youth consent to professionals within the facility who are involved with a youth’s care if it is related to the health or safety of the youth, other residents, staff, or the facility itself.

Mental health staff should be discreet and only disclose information that is absolutely necessary to help other professionals safely supervise and manage mentally ill youth. Even if mental health information can be disclosed, clinicians are not obligated to provide it if they believe disclosure is not in the best interest of a particular youth; in the spirit of collaboration, this should not be a frequent occurrence.

Key Role of Line Staff in Mental Health Treatment

Effective facilities understand the important connection between youth and responsible, caring adults. Line staff are in an ideal position for this responsibility and are some of the most consistent adults in the lives of repeat offenders or those with lengthy sentences. Trust is built during day-to-day interactions, and many youth with mental health disorders share more details about their lives and suffering with line staff than mental health clinicians.

Many youth respect, admire, and become emotionally attached to staff; their understanding of a youth’s mental health issues can facilitate the growth of this relationship and help it remain strong. Attachments between line staff and youth can actually reduce the impact of negative events in a youth’s life.[77] In small and mid-size communities, youth and staff may know each other from the “outs”—they may live in the same neighborhood or even be extended family members. This can positively impact their relationship, or in some circumstances may be an obstacle to overcome.

The saying, “I can’t hear you because your actions are so loud” is relevant to the way youth continually observe line staff. How staff cope with stressful individuals and events on the unit likely teaches youth more than anything staff can tell them.

Mentally ill youth instinctively know when staff care about them and what they have been through. Some staff heavily invest in youth success; at times working harder than youth do for themselves, and believing in youth more than they believe in themselves. Staff may not be formally trained as counselors, but informal counseling occurs throughout facilities during card games, watching television, shooting hoops, lifting weights, or just passing time on the unit. Line staff will never know the number of seeds they planted or “aha moments” they have been responsible for. They will never know how many suicidal juveniles chose not to take their lives because of the support or concern they knowingly or unknowingly provided. The number of juveniles who call or send letters to staff after release is a testament to this critical connection.

Psychotropic Medication and Youth in Custody

Many youth in custody take psychotropic medication to help control their moods or behavior. It can be vital to a youth’s success, and for some, it is lifesaving. However, the benefit and safety profiles of many of these medications are largely unknown for adolescents. Other than stimulants, there are few studies that examine the long-term impact of taking psychotropic medication beginning in childhood or adolescence. The limited data that are available are not encouraging.[78] Therefore, professionals who prescribe these powerful medications must exercise caution.

Psychotropic medication is particularly complicated and potentially dangerous among justice-involved youth because they often:

- Do not take psychotropic medication as prescribed.
- Take several different types of psychotropic medication simultaneously.
- Use alcohol or other drugs while taking psychotropic medication.

No research exists on the above issues, even among youth in the community.

Even if they agree to remain substance-free upon release, youth are likely to return to alcohol or other drug use. This can interfere with the therapeutic benefits of the medicine, as well as be physiologically harmful—or potentially lethal. Highly addictive medication should not be prescribed to youth in custody.
Psychotropic medication should only be considered if youth are 1) experiencing major distress, 2) in danger of harming themselves or someone else, or 3) experiencing major problems in day-to-day functioning. These brain-impacting medications should not be prescribed solely because youth are loud, annoying, or defiant. Psychotropic medication is only one piece of a comprehensive treatment plan and should be used after a youth’s mental health diagnosis is validated and non-medication approaches have been tried and proven unsuccessful.

When administered appropriately, psychotropic medication can help stabilize youth behavior so they can participate in programming and interventions. For example, youth with ADHD may be unable to sit still and focus during treatment groups, psychotic youth may be too confused to interact with peers, and depressed youth may be so preoccupied with thoughts about dying that they cannot concentrate in school. Some youth with mental health disorders struggle with basic token economy programs or skill-based treatment groups because of difficulty controlling their emotions and behavior. Not every problematic youth requires medication; most need to learn skills to regulate their emotions, modify their thinking, behave pro-socially, and cope with current stressors.

Youth who are prescribed psychotropic medication should be educated about their medicine in a brief, understandable way, including:

- Why a particular medication has been prescribed for them.
- What positive behavior changes are expected to occur from taking the medication.
- How the medication works within their body.
- Potential side effects of the medication (how common or rare) in case they experience unusual bodily changes.

Many youth in custody who have taken psychotropic medication for years have never received this type of information.

Despite similar rates of mental health disorders, lower rates of psychotropic medication are observed among African-American and Latino youth;[29] Asians, African Americans, and to a lesser extent, Hispanics respond to lower doses of some psychotropic medications, and may have more side effects even at lower doses.[30]

Ensuring that youth completely swallow their pills (versus “checking” them or vomiting them up) prevents youth from storing up their medication and overdosing. It also reduces opportunities for youth to sell or trade their pills as part of a black market, or for peers to obtain substances that are not prescribed for them. When youth have difficulty swallowing pills, medical staff can often crush them or order a liquid form of the medication, if it is available.

Medication Refusal Among Youth in Custody

Youth cannot be forced to take prescribed psychotropic medication, except in specific situations defined by law (e.g., imminent threat to self, peers, or facility staff). Parents or caregivers should be contacted if a youth’s repeated refusal of psychotropic medication places him or her at risk. Reasons for refusing medication among youth in custody are varied, but usually involve one or more of the following:

- Not wanting to be viewed as “crazy.”
- Bothersome side effects.
- Believing that medication is not helping or making them worse.
- Difficult swallowing pills.
- Adolescent autonomy and independence.
- Sedation and fuzzy thinking, making them vulnerable among dangerous peers.
- Wanting control in a setting where they have little say.
- Parents or caregivers are opposed to it.
- Psychotic beliefs the medication will harm or kill them.

When administering medication, staff can reduce a youth’s embarrassment or stigma by not shouting a youth’s name aloud in front of peers and not requiring them to go to a public and visible area. Providing opportunities to make choices in programming and other areas of treatment can help, if control is an issue.

Psychotropic Medication Side Effects

Psychotropic medication has side effects—some mild, some serious—and juvenile justice and mental health staff should receive basic training on those that are most common. Increased irritability, lethargy, and restlessness are side effects that often lead to negative responses from staff, as well as sanctions for youth.
As previously mentioned, avoiding unpleasant and uncomfortable negative side effects is a frequent reason that youth refuse their medication. Potential side effects include:

- Headaches.
- Insomnia.
- Major weight gain or weight loss.
- Nausea or stomachaches.
- Fatigue or drowsiness.
- Rapid or skipping heartbeat.
- Constipation.
- Dry mouth.
- Dizziness or lightheadedness.
- Skin rash.
- Irritability.
- Blurred vision.
- Loss of appetite.
- Restlessness.

A lower dose or different, but comparable, medication may alleviate youth discomfort. Abruptly stopping psychotropic medication can be dangerous; discontinuing these medications should be gradual and done under the supervision of a medical professional.

Because some antipsychotic medications can cause significant weight gain, diabetes, and metabolic disturbances, they should be prescribed only when absolutely necessary. Sedation or drowsiness is a common side effect of psychotropic medication; youth who cannot wake up in the morning, fall asleep during the day, or are completely out of it should be referred for a medication re-evaluation. The “start low and go slow” strategy is best when prescribing psychotropic medication to confined youth.

The healthcare administrator and mental health authority should work together to develop policies and formal guidelines that address:

- Prescribing psychotropic medication to confined youth.
- Continuing a youth's prescription of psychotropic medication when entering a facility.
- Medical monitoring of youth taking psychotropic medication.
- Communication, treatment linkages, and prescribing practices when youth are about to be released.
- Forced medication during emergency situations.

Prescribing physicians should make every effort to collect information about a youth's previous medications (e.g., which ones were helpful), review previous medical records, and consult with past treatment providers. Nursing staff can often help gather this information.

Policies and procedures related to identifying and correcting medication errors must be in place; all medication errors should be immediately reported.

Who Should Prescribe and Administer Psychotropic Medication

Due to the complex clinical picture of mentally ill youth in custody, plus the high percentage of co-occurring substance use disorders among this population, a child or adolescent psychiatrist or psychiatric mental health nurse practitioner trained in pediatrics is best for prescribing psychotropic medications and associated treatment. Facilities should ensure that the professionals who prescribe this type of medicine have the required education, training, and experience to work with incarcerated youth.

Medical staff should administer medication to youth. If this duty must be done by juvenile justice staff due to limited medical resources, medical staff must supervise and train staff (including routine refresher courses) on psychotropic medication including, but not be limited to 1) the different classes of medications, 2) identifying and dispensing medication, 3) immediate and long-term side effects, 4) responding to youth who have a bad reaction, 5) ensuring that youth swallow the medication, and 6) effectively handling medication refusal and noncompliance.

Interdisciplinary Team Approach
Communication, coordination, and collaboration are essential within facilities and between facilities. Neither juvenile justice nor mental health professionals can effectively manage youth with mental health disorders single-handedly. They must work closely with one another, with professionals from other disciplines, with a youth’s parents or caregivers, and with youth themselves. These key individuals must communicate, coordinate, and collaborate—formally and informally. Professionals from various disciplines should understand the roles of others, as well as how the work of other professionals impacts their own. Collaboration should begin at screening and continue through all assessment, treatment, and transition services. Important information from previous mental health and substance abuse evaluations should be communicated to and used by the treatment team.

Interdisciplinary Team (IDT) Meetings

Formal, structured IDT meetings should be held at least once or twice weekly based on the number of youth in a facility. A staff member from each discipline should be in attendance; the goal is to use the unique skills and knowledge of every individual in the room. When team members have different backgrounds, training, philosophies, work experience, and current roles, treatment plans tend to be more informed, comprehensive, and strategic.

At each meeting, the team should discuss:

- Youth progress toward treatment goals.
- Current barriers impeding youth progress toward goals.
- Youth achievements or positive behavior change.
- Youth disciplinary issues.
- How the facility and staff are positively or negatively influencing youth behavior. Additional strategies or resources that should be provided to increase or maintain youth positive behavior change.
- Appropriateness of goals previously established.
- Modifications to treatment plans, as needed.

IDT meetings should be welcoming and supportive, with input solicited from everyone attending. Parents or caregivers should be encouraged to attend IDT meetings (e.g., in person, by phone, or by webcam), as should key individuals from the community such as probation or parole staff, treatment providers, vocational or residential placement personnel, etc. If they are unable to participate, these individuals (especially parents or caregivers) should be encouraged to submit information (e.g., positive feedback, issues of concern, suggestions) in writing. The team should communicate this information during the meeting, and a designated team member should follow up with parents or caregivers to summarize all that was discussed.

Youth should be present for a significant part of the IDT meeting, be involved in the development and review of the treatment plan (versus solely being informed about it and providing a signature), and have the opportunity to ask questions, seek clarifications, and make requests. When a youth’s request cannot be granted, he or she should be given an explanation as to why and instructed on ways to earn it, if the request is reasonable.

Informal Consultation with Mental Health Staff

Mental health professionals who spend time on living units interacting with juveniles and line staff show themselves to be part of the team and build relationships and the trust needed for effective collaboration. Ideally, line staff should seek input from mental health professionals about managing mentally ill or difficult-to-manage youth. Mental health staff should regularly seek input from juvenile justice professionals about the youth in their care and strategies that have or have not been effective. Managing incarcerated juveniles with mental health disorders is made easier with information from mental health staff; mental health assessments and treatment are more individualized and effective with input from line staff.

Isolation of Youth with Mental Health Disorders

In this chapter, isolation refers to separating youth from other residents during non-sleeping hours by placing them alone in a small, locked room or cell. Isolation may occur in a youth’s room or a specially designed cell. Three of the most common types of isolation that juveniles with mental health disorders experience in custody are:

- Seclusion (Emergency Isolation).
- Room Confinement (Disciplinary Segregation).
- Protective Custody (Safety Housing).

*Facilities and national standards differ in the exact names used to describe these main types of isolation.
When youth behavior threatens imminent harm to themselves, others, or the facility, youth may be isolated as a safety intervention of last resort to contain their current acting out behavior, if staff have tried a range of less restrictive strategies and were unsuccessful. This type of isolation should only be used when absolutely necessary to help agitated, angry, aggressive, or out-of-control youth calm down and gain control of their mood and behavior. Youth should be secluded for the briefest amount of time possible—minutes, not hours or days—and only to the extent necessary to maintain their immediate safety or the safety of those around them. Staff should clearly explain to youth that they can return to programming as soon as they are calm and no longer pose a threat. Staff should observe youth on a 1:1 ratio and engage in crisis-intervention techniques while youth are secluded.[81] Seclusion should never be used as punishment. There is little to no quality research showing that seclusion is effective as a therapeutic tool; research that does exist shows that it can potentially be harmful.[82] If a QMHP determines that a juvenile needs more intensive crisis intervention services, the youth should be taken to a mental health or medical facility.

Room Confinement (Disciplinary Segregation)

Some facilities use isolation as a disciplinary measure when youth violate major facility rules or become violent or destructive; this is a response after the incident occurs. Room confinement is the most serious sanction given to youth in custody. Thus, it is “reserved for incidents in which the juvenile’s behavior has escalated beyond the staff’s ability to control the juvenile by counseling or other disciplinary measures and presents a risk of injury to the juvenile or others.”[83] The juvenile justice field is moving toward significantly reducing and eliminating room confinement for disciplinary reasons.

Judges involved with isolation-related litigation have set limits of two to five hours for the amount of time youth can spend in room confinement.[84] And one set of facility assessment standards prohibits the use of room confinement altogether for discipline or punishment.[85]

In the very rare event that room confinement lasts for longer than 24 hours, the American Correctional Association standards require a review every 24 hours by a facility administrator or designee who was not involved in the incident; and that room confinement for any offense should not exceed 3–5 days.[86] Youth who receive room confinement as a disciplinary measure should be given a maximum time limit, and a clear opportunity to return to general population sooner if they meet specific behavioral expectations.

Youth charged with major rule violations should have an impartial disciplinary hearing as soon as possible,[87] with a QMHP present to discuss what role, if any, the youth’s mental health, cognitive, or trauma-related symptoms played in the incident. Alternative dispositions to room confinement should be sought for all youth, but especially for those with mental health or trauma-related issues, low cognitive functioning, or organic brain damage; room confinement should never be used when these conditions are severe.

Staff must be protected—as must all youth in the facility—and accountability for violent behavior is essential. However, there is no evidence that room confinement decreases angry, aggressive, or destructive behavior. Lengthy periods spent in room confinement can cause psychological harm, are costly, and are likely to worsen behavior.

Protective Custody (Safety Housing)

Some facilities isolate youth who would be at increased risk of harm from other residents or themselves if placed in general population (e.g., youth in adult facilities; suicidal, self-injurious, severely mentally ill youth) as a form of protective custody. Although intended to be in the youth’s best interest, an isolated setting can negatively impact the mental health status of these vulnerable youth.

Youth in protective custody should not be treated as if they are on room confinement or housed with individuals isolated for disciplinary reasons. They should have similar socialization opportunities, environmental stimulation, access to programming (e.g., education, treatment groups), recreation, out-of-cell time, and privileges as youth residing in general population. Security and treatment professionals should work together to resolve the issue that necessitates the need for protection or find alternative permanent housing within the facility.[88]

Time Out

The use of "time-out" lasts 15–60 minutes and is used for minor violations or a cooling off period; youth return to the group once their negative behavior is under control.[89] Allowing youth to take a voluntary time-out can be particularly helpful to prevent major behavioral incidents for those with mental health or trauma-related disorders, intellectual disabilities, and organic brain damage. Time-out is typically not considered isolation.
Lengthy periods of isolation in correctional settings has been associated with uncontrollable anger, depression, confusion, memory problems, concentration problems, obsessions, paranoia, panic attacks, psychotic thinking, and suicidal and self-injurious thoughts and behavior—even among individuals without histories of these issues.[90] The degree of psychological deterioration in isolation varies and depends on several factors, including but not limited to: the duration of isolation, the intensity of social isolation, the extent of environmental deprivation, and whether the youth perceives the isolation as threatening or unjust.

Youth are inherently more vulnerable to the damaging effects of social isolation than adults; they are still developing cognitively, emotionally, physically, and psychologically. A study of suicide among incarcerated youth found half of those who died by suicide were on room confinement status at the time, and almost 2/3 had been isolated at some point.[91] Isolation can produce or exacerbate feelings of depression, hopelessness, agitation, and thoughts of dying.

Individuals with mental health and trauma-related disorders are also inherently more vulnerable to the potentially damaging effects of isolation. Therefore, incarcerated young people with these conditions have at least double the risk of psychological harm in less time due to the combination of their developmental level and mental or emotional issues. Youth labeled as “troublemakers” in juvenile and adult facilities are often “troubled” and typically need more socialization and programming, not less.

Isolation Policy and Daily Practice

Because isolation can exacerbate the symptoms of mentally ill youth or produce mental health symptoms in non-mentally ill youth, facilities should reduce this practice and work toward eliminating it. If isolation must be used, it should only be done as a response of last resort, used for the briefest amount of time possible, and only in extreme circumstances when it is absolutely necessary for safety. In addition, the following recommendations should be addressed in facility policies and daily practice with all isolated youth:[92]

- Policies and procedures should distinguish between the three types of isolation, and each should have its own set of clear guidelines; staff should be extensively trained on the different types of isolation, and the differences should be clearly explained to youth. QMHPs and physicians should be involved in the development of or review of all isolation policies and procedures.
- Before placement in isolation, youth should be screened by a QMHP for psychotic thinking, an intellectual disability, suicide risk, and other significant mental health issues to ensure that no contraindications for placement in an isolated setting are present. If so, a less restrictive setting should be sought and treatment provided to address the vulnerability.
- Decisions about the duration of isolation (and any associated restrictions) should be made collaboratively between juvenile justice and mental health staff, taking into account 1) the reason for isolation, 2) the seriousness of a youth’s dangerous or destructive behavior, 3) age, 4) mental health status, 5) prior behavior, 6) the current treatment plan, 7) any history of trauma, and 8) other relevant factors. Isolation should always be for the briefest time possible.
- Staff should visually observe and monitor youth in room confinement and protective custody at staggered intervals not to exceed 10 or 15 minutes (depending on youth behavior) and must document their observations. Youth in seclusion should be on constant 1:1 observation.
- In the very rare cases when youth are placed on room confinement for 24 hours or more, they should have an individually-tailored behavior plan (in addition to their treatment plan) that clearly identifies 1) why they have been placed in isolation, 2) positive qualities and strengths, 3) specific behaviors they must exhibit for room confinement to cease, and 4) what consequences will occur if behavioral expectations are not met. Youth may need assistance from staff in meeting behavioral expectations if they lack the skills to do it on their own. Youth should not be secluded for more than 4 hours.[93]
- If placed on room confinement or protective custody for over 24 hours, mental health, religious, administrative, and medical professionals should visit youth daily (in-person, not through a cell window or door). QMHPs should assess the psychological functioning of these youth once per day (more often if required) and provide mental health treatment as necessary. Staff should contact QMHPs regarding youth behaviors of concern, and juveniles should be able to request time with a QMHP.
- To prevent psychological deterioration, youth in isolation should have opportunities for meaningful socialization, educational or vocational activities, daily outdoor physical activity, adequate amounts of nutritious food, family contact, mental health treatment, and rehabilitative programming, even if delivered in small groups or individually (in cases of significant safety risk).
- Staff must observe isolated youth who become suicidal on a continuous, uninterrupted basis (e.g., 1:1) until the youth is evaluated by a QMHP. If found to be at risk, youth should remain on continuous observation. Rooms designated for
isolation purposes should be suicide resistant (see “Suicide Prevention” section of this chapter). Isolation is an extremely high-risk environment for suicide.  

- If suicidal, self-injurious, or seriously mentally ill youth must be placed in isolation, they should be out of their rooms and engaged in daily programming (with more intensive staff monitoring) as much as is safely possible. Juvenile justice staff and QMHPs should work together to help ensure these youth are out of their rooms and engaged in meaningful activities.
- Staff should talk with youth (using a nonjudgmental tone) to help youth identify what behavior resulted in their restricted placement and what they can do differently in the future to avoid a similar outcome.
- The isolation of youth in juvenile and adult facilities should be severely limited, rigidly regulated, and carefully monitored.

Wanting Time Alone

Some confined youth with mental health or trauma-related issues, low cognitive functioning, or organic brain damage want brief periods of time alone in their room when they 1) feel overly-stimulated by unit activity, 2) fear for their safety and want protection, 3) experience auditory hallucinations, 4) are easily annoyed by peers, 5) suffer from depression and want to withdraw, and 6) attempt to avoid school or other programming expectations.

When a particular youth is repeatedly placed in seclusion or room confinement, an IDT should explore whether he or she is intentionally getting isolated to meet a specific need; if so, intervention strategies should focus on resolving the underlying issues.

The Vicious Cycle

A small number of youth typically create the majority of behavioral disruptions in a facility. Incarcerated youth with mental health and co-occurring disorders, as well as those with cognitive issues (e.g., intellectual disabilities, organic brain damage) tend be at high risk to respond in ways likely to result in isolation because they often:

- Have more difficulty adjusting to incarceration.
- Are more impulsive.
- Are less able to control their moods and behavior than other confined youth.

Plus, traumatized youth are more likely to act out reactively due to their irritability, recklessness, and tendency to perceive hostility where none exists.

Lengthy periods of isolation characterized by sterile surroundings, and a lack of socializing and meaningful activity can be unbearable for these types of youth (sometimes triggering past trauma) and can result in additional negative behaviors (e.g., tearing up mattress, flooding the room, smearing or throwing feces). When negative reactions to being isolated lead to additional time in isolation and further restrictions, increasingly worse behavior invariably results. This vicious cycle can continue for days, weeks, or months—an unacceptable and avoidable situation.

When youth are repeatedly placed in isolation (including when a vicious cycle is at play), an IDT team should dedicate the necessary time and energy to identifying the exact dynamics at work and addressing those issues, with the goal of helping youth transition to less restrictive housing or an alternative setting. Creative problem-solving, individually-tailored treatment plans, and re-evaluation of current behavioral expectations are typically required. All interventions tried should be documented, along with their level of effectiveness.

Special Management Units

Some facilities have specialized disciplinary units that use isolation to house the most dangerous and unmanageable youth. Recommendations listed in this chapter to reduce the harmful effects of isolation are just as relevant to these special management units, if not more so. Although reserved for the most violent and destructive youth, specialized disciplinary units too often end up housing the most mentally ill and traumatized youth.

Special management units must be staffed by experienced and effective juvenile justice and mental health professionals who should have additional training on working with clinically complex youth who have mental health disorders, trauma-related issues, head injuries, cognitive disabilities, as well as criminal attitudes and behavior. Special management units should be staffed at a different ratio than general population units, with staff required to supervise significantly fewer numbers of youth.
Moving from a special management unit (e.g., intense structure, increased supervision, highly individualized programming) to general population can be overwhelming and stressful for young people. Youth should have a multitude of opportunities to earn increasing amounts of freedom and autonomy so they can practice necessary skills; this helps ease their transition to general population and keeps them from returning shortly after departing.

Solitary Confinement

| Solitary confinement—meaning social isolation for 22–24 hours, excessive idle time, and no access to education or vocation, treatment groups, or programming—is inappropriate and unethical for all youth (including those separated from adults for their own protection) and puts facilities at risk for litigation.[94] This is especially true for youth with mental health and trauma-related disorders, intellectual disabilities, or organic brain damage. |

**Restraint of Youth with Mental Health Disorders**

**Mechanical or Therapeutic Restraint**

Therapeutic restraint typically refers to the application of a device, material, or equipment that confines a youth’s bodily movements, restricts their physical activity, and which youth cannot remove. Some facilities use “therapeutic” or soft restraints such as fleece-lined leather, canvas, or rubber hand and leg restraints.[95] Their use in juvenile and adult facilities should be exceptionally rare—only in emergency situations where 1) youth are an extreme and imminent danger to themselves, staff, or peers and 2) less intrusive and intense measures to help youth gain control of their behavior were tried and were ineffective. Many youth who become restrained while incarcerated suffer from mental health and trauma-related disorders, intellectual disabilities, or organic brain damage.

**Restraint Policy and Practice**

Because restraints can be physically dangerous and psychologically traumatizing for both youth and staff (especially those with histories of abuse and trauma), restraints should always be an emergency response of last resort. Serious injuries and deaths have occurred as a result of restraint—even when properly applied.[96] Therefore, medical and mental health personnel should be involved in the development and review of all restraint policies.

Youth must be clearly told, and calmly reminded, the exact behavior they need to demonstrate to be released from restraints; restraints must immediately cease when they exhibit that behavior. Restraints should never be applied for a pre-determined period of time or be used as discipline, retaliation, or as a quicker or easier way to elicit compliance.

Placing a youth in restraints should require approval from administration (e.g., superintendent, warden, director) and a mental health or health care authority. Restrained youth must be continuously monitored, and the continuing need for restraint must be documented every 15 minutes. A QMHP and licensed medical professional should assess a youth’s psychological and physical health every 15 minutes and determine if the youth should be transferred to a medical or mental health facility.

Debriefing with youth and staff is essential after every restraint; parents or caregivers should be contacted to discuss what occurred and to elicit suggestions regarding effective strategies with their child.

**Unnatural Positions and Fixed Restraints**

Juveniles should never be restrained in unnatural positions such as face down, hog-tied, or spread-eagled.[97] Some national standards prohibit the use of soft restraints as well as fixed or four- or five-point restraints (e.g., restraining a youth’s arms, legs or head to a stationary object such as a chair or bed).[98] Moving Away From Hardware: The JDAI Standards on Fixed Restraints provides a detailed description of the dangers inherent to fixed restraints and why JDAI believes a complete ban of such methods and equipment is necessary.[99] Other national standards permit the use of soft restraints and approved fixed restraints, although only in extreme circumstances.[100] Facilities should eliminate the use of fixed therapeutic restraints (including restraint chairs) and work toward ending the use of soft restraints with youth, using alternative and less restrictive management strategies instead.

**Restraint-Related Training**

Every professional who could potentially be involved in restraint incidents (e.g., ordering, approving, applying, assessing) must receive restraint-related training and practical coaching and must demonstrate competency in his or her particular role.
Training should include verbal de-escalation, conflict resolution, and crisis intervention with volatile and violent youth, including those with mental health or trauma-related disorders, intellectual disabilities, and organic brain damage. Training should address the small, but incredibly difficult-to-manage group of youth who want to be restrained and who intentionally engage in highly dangerous behavior to force staff to restrain them.

Oversight of Restraints

The use of therapeutic restraints should be meticulously monitored, with rigorous multi-disciplinary review and administrative oversight. The inappropriate or unnecessary restraint of youth should be immediately addressed and corrective action taken. Videotaping restraint incidents can provide essential footage for incident review, training, and staff coaching.

Reducing the Isolation and Restraint of Youth in Custody

Decreasing, and eventually eliminating, the isolation and restraint of youth housed in juvenile and adult facilities (e.g., frequency, duration, and severity) typically requires 1) a major cultural shift involving everyone from administration to line staff, 2) significant staff training, 3) practical coaching on the units, and 4) accountability for staff behavior (e.g., rewarding effective use of less restrictive management strategies, disciplining inappropriate use of isolation or restraint).

As the number of youth in custody decreases, those who remain in confinement are typically the most violent, mentally ill, criminal, or difficult to treat. Managing unpredictable, volatile, and aggressive youth can be demanding, draining, and dangerous. Reducing isolation and restraint at a time when facilities primarily house youth who have difficulty regulating their emotions and behavior, or who are prone to use violence to solve problems, is a complex and multi-dimensional endeavor.

When asked to decrease or eliminate isolation and restraint, it is natural to ask, “What major disciplinary measures can we use instead of isolation?” or “How are we supposed to contain youth when they are out of control?” Fred Cohen, national expert in correctional mental health law, stresses that it is more helpful for facilities to focus on “What can we do to help prevent incidents requiring isolation and restraint from happening in the first place?”[101] These dialogues go beyond examining what triggered a particular incident. We often need to take 10 or 20 steps back to explore how a situation or an individual got to the point where such extreme measures were necessary, and what adjustments and modifications may need to occur.

According to Cohen, disruptive behavior should not be viewed as a violation and disciplinary event; instead, it should be seen as acting out and be dealt with as part of a treatment or behavior management protocol.[102] Dynamics between staff and aggressive or acting out youth improve when staff members prevent confrontations, de-escalate provocative situations, and model calm responses to insults and threats.[103]

Balancing safety and security with youth rights and effective treatment and rehabilitation is often extremely challenging. Implementing the strategies in this chapter (e.g., adequate staff-to-youth ratios; effective behavior management strategies; well-trained staff; screening and assessment of mental health, co-occurring, trauma-related, and organic brain disorders; individual treatment plans; positive youth–staff relationships; mental health and trauma-responsive treatment; cognitive-behavioral therapy; developmentally appropriate evidence-based programming and skill-based groups) can help facilities move toward that balance and hopefully reduce the need for isolation and restraint.

Transitioning Youth with Mental Health Disorders Back to Community

When not adequately prepared for the transition from confinement back to the community, youth with mental health disorders can become overwhelmed, frustrated, and discouraged. Treatment gains may disappear if appropriate support services are not in place. Because mentally ill youth often have multiple needs upon release, they typically require support and services from multiple systems.

- Family.
- Mental health.
- Substance abuse.
- School or vocational.
- Housing.
- Child welfare.
- Medical.
Family involvement is essential; effective behavior management strategies should be reviewed, encouraging parents or caregivers to reinforce pro-social youth behaviors at home and to discipline or not reinforce negative and antisocial behaviors. Realistic rules and family boundaries should be discussed and clearly explained to youth before they leave the facility. Prior to release, youth who receive mental health services (including medication) during confinement must have an appointment scheduled with a mental health professional in the community. Efforts must be made to link youth with treatment providers with whom they already have a relationship. Youth with mental health disorders must be engaged in school or work[104] and they often need assistance choosing peers and how to spend their free time.

The Bridge Program at the Juvenile Temporary Detention Center (JTDC) in Cook County is one example of a collaborative partnership that focuses on successfully transitioning mentally ill youth back into the community.

Coordinated Case Management

Case managers can 1) build relationships with community providers, 2) connect youth to relevant services, 3) keep track of a youth’s treatment progress, 4) monitor a youth’s compliance with conditions imposed by the court, mental health providers, and any other relevant agencies, 5) engage and motivate youth and their families, and 6) help resolve the sometimes-conflicting interests of youth, their parents or caregivers, the juvenile justice system, and mental health treatment providers. Case management works best if it is initiated when youth enter a facility and then follows youth as they move the phases of the juvenile justice continuum. If formal case managers are not available, probation or parole officers, treatment providers, or child welfare representatives can coordinate the myriad of services youth with mental health disorders require and serve as the central individual with whom everyone communicates.

A variety of individuals involved with a youth’s supervision and treatment should provide input into community transition plans; they should be written in objective language understood by youth, their parents or caregivers, and professionals from diverse systems. [See Ch. 18: Transition Planning and Reentry] 18

Housing Issues

Youth with serious mental health disorders may require specialized residential placements or specific intervention services immediately upon release, including 1) an inpatient psychiatric hospital, 2) a day treatment program, 3) therapeutic foster care, and 4) intensive home-based treatment. Parents or caregivers may need crisis intervention services or access to respite care. Some parents or caregivers may not have the capacity or willingness to take care of mentally ill youth upon their release from custody. Every effort should be made to connect youth with family members (even if they are distant relatives or do not live nearby) rather than out-of-home placements.

The longer youth with mental health disorders have been incarcerated, the more aftercare services they typically require due to the extreme change in circumstances; these youth require a gradual transition back into the community. Allowing youth to visit their family home or reside for a short time in a less restrictive residential setting (e.g., step-down program, group home) helps them practice functioning with fewer external controls before fully returning to the community.

Probation and Parole

Youth are more likely to attend and participate in mental health services after release if services are mandated by probation or parole. Positive incentives for treatment compliance are essential; however, the fear of sanctions for noncompliance is also a powerful motivator for many youth and their families. Probation or parole should maintain regular contact with mentally ill youth to monitor their involvement at home, in school or work, and with peers; they should be alert to a worsening of a youth’s functioning or a return or exacerbation of mental health symptoms. As they reintegrate, youth need stable adults to provide support during challenging times.[105] Probation or parole staff are in an ideal position to serve in that important role. In addition, random drug testing with youth who have co-occurring disorders can strengthen their motivation to remain clean and sober.

Mental Health Training Is Essential

Working with youth who have mental health, substance use, co-occurring, and trauma-related needs, is physically and emotionally stressful.

When juvenile justice staff receive little or no training on these issues, they can easily become frustrated and discouraged, leading to burnout and ineffective—and sometimes harmful—management strategies. Without training on how to effectively manage youth with mental health disorders, staff can unintentionally escalate a crisis situation, exacerbate distress, or trigger
a deterioration of a youth’s symptoms. This is dangerous for both youth and staff. Other reasons staff require this training include:

- Youth with mental health disorders spend significantly more time with line staff than with mental health staff.
- Line staff can manage youth more strategically if they understand a youth’s key issues.
- Line staff are in an ideal position to detect a youth’s mood and behavior changes.
- Line staff are central members of the treatment team.
- Some juvenile justice staff administer mental health screening tools.
- Every interaction between mentally ill youth and line staff can positively or negatively impact youth.
- Some line staff do not believe in “mental illness” and assume youth are faking symptoms to avoid tasks or responsibilities.
- Line staff can misinterpret a youth’s mental health symptoms as attention-seeking or as defiance.
- Positive relationships between youth and line staff are vital and can serve as a protective factor for a youth’s future.
- Training staff on the identification and management of youth in custody with mental health disorders can reduce liability.

In addition to providing informal counseling to youth, line staff refer youth of concern to mental health professionals, provide critical information regarding youth behavior, give feedback about medication side effects they observe, and report on whether medication seems to be positively impacting a youth’s behavior. Even when trying to do the right thing, staff may unintentionally reinforce a youth’s aggression, angry outbursts, self-injury, and medication refusal if staff do not know how to respond effectively. In addition, when line staff view legitimate symptoms of mental illness as purposeful, oppositional, or manipulative, youth with mental health disorders can receive a multitude of negative consequences, more restrictive placements, and longer periods of confinement.

Providing mental health training to all staff increases safety and the effective management of troubled youth; it is also an important way a facility or agency can demonstrate that it is not deliberately indifferent to the needs of the mentally ill youth in their care—something for which detention and correctional facilities can be sued.

A survey of correction officers found the following:[106]

- 90% said that working with mentally ill offenders adds to the stress of the job.
- 86% said the training for their current job did not prepare them to work with offenders who have mental health disorders.
- 95% said they wanted more training to deal with mentally ill offenders.

Although the study involved staff who work with confined adults, the same sentiments are consistently found among those working with incarcerated youth.

Training all staff (direct-care to administration) on the following topics is essential to running safe and secure living units and meeting the needs of confined youth:

- Identifying and managing incarcerated youth with mental health, substance use, co-occurring, and trauma-related needs.
- Effective behavior management with clinically complex and difficult-to-manage youth, including effective alternatives to isolation and restraint.
- Suicide prevention specifically related to youth in custody.

For this chapter, these three types of trainings are included under the umbrella term "mental health training."

Who Should Attend Mental Health Training?

Anyone who has direct contact with incarcerated youth will come into contact with those who have mental health disorders. Therefore, the following professionals should receive mental health training:

- All levels of juvenile justice staff.
- Teachers, principals, and school psychologists.
- Vocation, recreation, art, and occupational therapy staff.
- Mental health, substance abuse, and sex offender treatment providers.
- Maintenance and food service staff.
- Chaplains.
- Medical personnel.
Training a diverse group of participants is a good way to bring together the various disciplines that must collaborate and coordinate the care of youth with mental health disorders. The training itself can help the members of different systems learn more about one another and serves as a starting point for making professional contacts and exchanging ideas.

Staff must also effectively coordinate and collaborate within their own discipline. Staff teams, as well as entire units or facilities, have lost focus and ended up in chaos over the management of seriously mentally ill youth. Half the staff believe that certain youth are faking symptoms and should receive restrictions and consequences for their negative behavior; other staff want youth to receive extra support and fewer behavioral expectations. This type of division is common and detrimental to youth with mental health disorders, staff teams, and living units. Therefore, sending entire staff teams to mental health training ensures that they all hear the same information and recommendations. Admission or orientation units, specialized mental health units, and disciplinary units should have first priority to attend mental health training, because they supervise the largest numbers of mentally ill youth.

**Key Components in Mental Health Training**

Mental health trainings can often be perceived as dry, boring, or discouraging. The following factors help keep staff engaged and increase the likelihood they will walk away with new mental health knowledge and skills:

- Making complex clinical material easy to understand.
- Ensuring the material is relevant to the type of facility, participants’ job duties, and available mental health resources (or lack thereof).
- Employing trainers with extensive knowledge and experience in *both* mental health disorders and juvenile justice settings.
- Employing down-to-earth trainers who recognize the expertise of juvenile justice staff.
- Recommending specific, practical, and easy-to-implement strategies.
- Scheduling the training so there is adequate time to cover the material and allow for questions and clarification.
- Using real-life case examples of youth in custody with mental health disorders.
- Presenting the material in a variety of modalities (e.g., slides, video clips, lecture) and involving participants (e.g., small- and large-group activities, role playing).

Following mental health training, juvenile justice staff often describe having 1) a better understanding of youth with mental health disorders, 2) more confidence managing youth with mental health disorders, 3) an increased willingness to communicate and collaborate with mental health staff, and 4) an appreciation for why mental health issues should be integrated into juvenile justice treatment plans.

Mental health professionals often need training on safely and effectively providing care in correctional environments. Graduate programs typically do not prepare clinicians to work with potentially dangerous youth who have clinically complex emotional and behavioral conditions. Plus, there may have been significant advances in the field since they received their degree or licensure. In addition to attending relevant trainings that juvenile justice staff receive (e.g., mental health, suicide prevention, and effective behavior management) mental health professionals need information on evidence-based screening and assessment, and on providing evidence-based individual, group, and family therapy specifically with incarcerated juveniles.

Given the high numbers of incarcerated youth with mental health, substance use, co-occurring, and trauma-related disorders, mental health training for all staff should be mandatory.

**Conclusion**

Ideally, justice-involved youth with mental health, co-occurring, and trauma-related disorders are held accountable and receive appropriate treatment in the community; all systems should be working toward that goal. When these youth must be placed in juvenile detention, juvenile corrections or adult facilities, much can be done to reduce the potential harm and increase the positive changes these young people experience.

For more information:

- [Mental Health and Substance Abuse Hub](https://www.nicic.gov) at the Juvenile Justice Information Exchange
- [The National Child Traumatic Stress Network (NCTSN)](https://www.nctsn.org)
- [Effective Child Therapy (Evidence-Based Treatment)](https://www.childtreatment.org)
- [Prison S.M.A.R.T.](https://www.prisonsmart.org)
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