

Mental Health Rehabilitation of Detained Juveniles: Using Time Wisely

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The worst punishment for a young man is not death, but time.—Juvenile recidivist

The rehabilitation potential of mentally ill juvenile offenders should be at the forefront of the forensic mental health debate, because these youths mature into adults who may continue to have mental disorders and to offend. In view of this concern, the importance of using juvenile detention facilities as vehicles for youth reform cannot be overstated.

Juvenile justice reform is a relatively recent concept in the United States. In the late 19th century, social activists theorized that poverty and social conditions resulted in juvenile offending. The reformers favored the English common law philosophy of *parens patriae*, which permitted the state to function as a parent would in the life of all children within its borders. Youths were not believed responsible for individual offenses that were attributable to poor supervision, support, and discipline. Although several jurisdictions responded to a growing need for youth supervision and guidance by separating juvenile proceedings and youth offenders from adults in the late 1800s,¹ the practice expanded after the Illinois Legislature codified it in the Juvenile Court Act of 1899.² This legislation established a framework for juvenile justice systems. The Act made clear distinctions between neglected and delinquent offenders, authorized a separate court system for juveniles between the ages of 7 and 16 years, established a structure of special procedures for juvenile hearings, and

provided for a juvenile probation system. It was not the intention of the juvenile courts to usurp the autonomy of parents, but instead to reinforce the sense of responsibility of the child and the parent.³ To support this goal, the Act provided for psychosocial assessment teams that evaluated children and informed the court about what was needed to rehabilitate each youth. These child guidance assessment teams were the kernel from which the subspecialty of child psychiatry evolved.⁴

During the first half of the 20th century, inadequate funding and other structural and philosophical barriers hampered the efforts of the juvenile justice system to reform young offenders. Regrettably, since then, the rehabilitative model of juvenile justice has gradually been shifted to focus on retribution and punishment. In response to this change, the U.S. Supreme Court has afforded juveniles increased due process rights during court proceedings.⁵ The Court also raised the required legal standard in delinquency hearings from best interests to the standard of beyond a reasonable doubt that applies in criminal hearings.⁶ The Court has confirmed rights for youths who are at risk of having their cases transferred to criminal court, including the right to a defense, access to salient records, and a judicial explanation of findings when the case is transferred.⁷ In 2005, the U.S. Supreme Court banned executions of inmates who committed offenses before the age of 18 years.⁸

Society's response to increased liberty interests and rights for juveniles in court has included legislating more severe consequences for juvenile offenders, including but not limited to charging younger juveniles as adults for a greater variety of offenses. There

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has been less societal pressure to rehabilitate youths accused of juvenile offenses, even though we know more than at any time in history about the phenomenology, treatment, and relapse prevention of disruptive behavior, including that which can be attributed, at least in part, to mental illness. As community crises such as inadequate community mental health resources become more prevalent, the proportion of youths with mental disorders in juvenile detention facilities has escalated. The fact that a small subset of youths and their families decline recommended mental health and other rehabilitation services does not justify depriving all detained youths of opportunities for therapeutic reform.

Recent class action litigation against residential juvenile detention facilities has centered on inadequate conditions of confinement, including mental health care.^{9,10} Institutionalized youths should be rehabilitated in humane, safe environments that offer mental health assessment and, when applicable, treatment. The importance and necessity of clinical intervention are obvious. As in the community, a detained youth with a mental disorder who has improved impulse control, sleep, concentration, anger control, patience, and motivation as a result of competent mental health care, is more likely to benefit from educational and corrective rehabilitation than is a child whose mental health needs are not identified and addressed. Therapeutic stability should enhance a youth's ability to follow directions, to make positive choices, and to be future oriented. Failure to treat a mental disorder may contribute to the child's feelings of helplessness and hopelessness, suicidal ideation,¹¹ self-injury, and aggressive behavior that may in some cases result in the youth's having additional legal problems and an extended residential commitment. Staff injuries and turnover may also be reduced if youths are in better control of their emotions and behavior. Therefore, competent juvenile mental health care in detention facilities is conducive to safer environments for youths and staff.

The prevalence of mental disorders in youths remanded to juvenile detention centers is substantial. Teplin and colleagues¹² determined that, when conduct disorder was excluded, the prevalence of mental disorders in a juvenile detention population was 70.0 percent for girls and 60.9 percent for boys. The same data set showed that 75 percent of detained youths met criteria for more than one psychiatric disorder.¹³ Consequently, if we are to rehabilitate detained youths,

timely mental health screenings of all youths are necessary to identify those who could benefit from services.¹⁴ Although detractors may suggest that mental health rehabilitation is not possible in a detention center due to high turnover and brief stays, Desai and colleagues¹⁴ describe effective approaches to mental health screening and treatment in juvenile detention facilities. To that end, the following examples illustrate successes that may be achieved when quality developmentally informed mental health services are available to detained youths. The composite case examples, which represent no particular individuals, describe ways in which youths have benefited from medication therapy and counseling.

Case Example I

This example involves a preadolescent male who was referred for mental health services. He was irritable, aggressive, and hostile toward his elderly caretaker, who had raised him and his siblings for several years. Even though he did not share their interests, he wanted to be accepted by his siblings and peers, but was teased by them instead. Although he responded well to treatment for depression, continued clinical intervention proved challenging because his caretaker was often overwhelmed and forgetful. Since he was helping his caretaker raise his younger siblings, he did not have the free time to engage in developmentally appropriate, peer-centered activities. Counseling services were not available to this youth in the community.

When he was in high school, he proclaimed innocence when he was accused of a violent offense, and he insisted that he had an alibi. He was detained at a local juvenile detention facility, where he was teased by the youths and a few staff members. He remained polite, complied with medication therapy, participated actively in counseling, and remained focused on his future. He applied himself in school and participated in recreational programs until his hearing. Several community leaders came to court to support him, and he was released on probation.

Several weeks later, he was remanded to the juvenile detention center because his caretaker was hospitalized, and there was no other adult available to supervise him and escort him to probation appointments. He was determined not to let this setback hinder his progress. He participated in every therapeutic activity that was offered to him. He continued with mental health counseling and applied himself in

school. For the first time in his life, he chose to participate in sports and religious activities. He met volunteers and community leaders who spoke about career choices and mentoring programs.

Soon thereafter, he began to plan for his release from the detention facility. He coped well when his release date was postponed. He compiled a list of goals for his future, which included attending religious services, enrolling in a mentoring program, transferring to a school that would better prepare him for college, and developing a flexible 5-year plan to achieve his academic and professional goals. He said that being detained changed the trajectory of his life. His detention experience opened his mind to new and positive opportunities.

In addition, he decided to sever relationships with negative peers and adults. He said that his greatest accomplishment during his detention commitment was realizing that he had the potential to make a substantial contribution to society.

Detention staff recognized his remarkable coping skills and emotional growth. They began to encourage other youths to view him as a model of what they could aspire to be and do. On one occasion, he was hassled by a staff member. The teen decided that he couldn't afford to have a conflict with staff, and so he isolated himself in the quiet room until the staff person's work shift ended. The situation was handled to the youth's satisfaction the following day.

Although this individual's accomplishments in academics, career planning, self-acceptance, spirituality, athletics, and interpersonal skills do not represent the average youth's development in a juvenile detention facility, the services that are available, even in facilities with few resources, can be accessed in various combinations to aid individual youths in changing their behavior and outlook.

Case Example 2

The second example involves a girl in her early teens who was remanded to a juvenile detention center for the complaint of domestic violence against her caretaker. She had been released from the facility earlier in the year; this commitment was her third. She was referred to the mental health team by her peers, because she provoked them to fight her, and they didn't want to get into trouble. Her peers, who were also repeat offenders, reported that she had stolen their personal belongings and then had insisted that the people in stolen photographs were her family

members. She further antagonized the other youths by insisting that everyone in the pictures had a potentially fatal infectious disease.

She had not taken medication for six months because she believed that it didn't help her. She was jovial and distractible, but she was not considered disruptive by staff, who explained that her behavior was more manageable than it had been during her previous commitments to the facility. Further inquiry revealed that she was hyperactive, impulsive, and distractible in class and in the residential unit. She agreed to take a different type of medication; she said she was functioning much better; she was more attentive and calmer. Her peers stopped complaining about her, and she received positive reinforcement from them, the staff, and the teachers. When she was ready to be released from the detention facility, her community-based management team expressed concern that the detention mental health team had prescribed her the wrong medication and had made the wrong diagnosis. The mental health treatment team received authorization to review her diagnostic data and treatment response with the community-based management team. A detention mental health counselor supported the youth as she advocated for herself based on her understanding of her mental disorder and her response to treatment. Three years later, the teen is functioning well in the community.

Conclusions

Although these case studies are anecdotal, they reinforce an important truth: youths can be rehabilitated in detention centers. Detained individuals who have mental disorders must be identified¹⁵ and receive developmentally informed mental health care as an essential component of their rehabilitative program. In juvenile detention facilities, developmentally astute mental health providers should be expected to collaborate with and educate the staff, the youths, and their caretakers. The importance of mental health intervention for youths in detention must be emphasized. When a youth with mental illness is detained, he is, by definition, impaired, at least in part by psychiatric symptoms that did not facilitate his choosing alternatives to legal involvement. A youth who is in control of his emotions is in a better position to shift his life's trajectory toward a more favorable endpoint, whether or not he is being detained. At times, when a youth does not seem to be interested in rehabilitation, exposure to the treat-

ment process as a stakeholder with decision-making ability may render him more amenable if he is able to internalize the goal of self-improvement and to make it a central life concept.

A youth in detention said, "The worst punishment is not death; the worst punishment is time." He explained that time is worse than death, because death results in a permanent cessation of suffering for the decedent. Time, on the other hand, gives the individual a chance to think about what he's missing, whom he has harmed, and what he did wrong. Time also gives each youth an opportunity to take advantage of a variety of rehabilitative interventions that should be available in each juvenile detention facility. Wellness, education, an internal locus of control, maturity, and a sense of responsibility should be goals for detained youths as they progress toward adulthood.

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