Commentary: The Role of Mental Health Services in Preadjudicated Juvenile Detention Centers

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The role of preadjudicated juvenile detention centers (JDCs) in treating children and adolescents with mental health needs has continued to receive national attention. Legal actions mandating improved health care services over the past decade, coupled with a national focus on detainees' mental health needs, have led to the increased presence of mental health professionals in JDCs. In this context, we must build on the current "call to action" and develop innovative blueprints for the provision of mental health services for detained youth. Although operationalizing this movement is complicated, we must be prepared to sustain its effects by developing effective communication and planning among correctional health care organizations, universities, municipalities, and other stakeholders.

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The role of preadjudicated juvenile detention centers (JDCs) in treating children and adolescents with mental health needs has continued to receive attention in the literature and nationally.[1] In 2002, Teplin *et al.*[2] reported that up to 75 percent of youths in juvenile detention centers in the United States had one or more psychiatric disorders. While Grisso[3] suggests that the prevalence rates for mental disorders may be higher or lower, depending on how the term "mental disorder" is defined, the consequences of untreated mental illness and/or substance abuse are clearly of great concern to us all.

Mental Health Services in the JDCs: Can We Sustain the Positive Effects?

Legal actions mandating improved health care services over the past decade,[4] coupled with a national focus on detainees' mental health needs, have led to the increased presence of mental health professionals in JDCs. However, since work in JDCs is a relatively new practice area, clinicians have faced predictable challenges in adapting mental health services to these unique settings. Moreover, professionals have also found that developing mental health services in JDCs is a complicated undertaking, one not well documented or even understood by most clinicians outside the system.

Many practitioners and researchers have made significant contributions to the literature in this field, taking into account the complexities associated with providing services in these settings.[5] Examples of some of these efforts include work on practice parameters,[5] intake and screening procedures,[6] and innovative juvenile detention programs.[1] The National Center for Mental Health and Juvenile Justice[7] has also provided critical support to practitioners, while the National Commission on Correctional Health Care (NCCHC) has extended a guiding hand through its work on juvenile mental health standards.[8]

Given the current momentum of the juvenile justice and mental health movement, and the gains just mentioned, Grisso's article is a timely contribution to the field.[3] In it, he credits a publication edited by Joseph Cocozza in 1992[9] as being the early foundation for the juvenile justice mental health movement. Cocozza's work, largely seen as a "call to arms" by experts, summarized information related to the prevalence, identification, and treatment of mental health disorders in the juvenile justice population.[9]

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After reviewing Grisso's article, one cannot help but see it as a second call to action. The current focus on detainee mental health cannot last forever, and further thoughtful action is necessary to sustain gains and capitalize on the movement's progress to date. To place this nationwide challenge into context, Grisso reflects on four "reforms" in America's juvenile justice system and the need to sustain these effects in the long-term.[3]

How can we then ensure that the positive effects of this mental health movement will continue? Grisso states that we cannot depend only on short-term initiatives by government and/or advocacy groups.[3] Instead, he looks to the development of alliances between juvenile justice and mental health agencies, as well as the potential restructuring of public agencies, to improve the fulfillment of children's mental health needs. As practitioners and administrators in the field, we could not agree more with this viewpoint.

In concert with these efforts, advocates and policy makers should also take this opportunity to capitalize on the contributions that have already been made by Roush and the National Juvenile Detention Association. (NJDA became one of four founding members of the National Partnership for Juvenile Services [NPJS][10] in 2004.) Roush and the NJDA had long utilized the term "helpful services" to define the essential work of the JDC and had included mental health services under the umbrella of "helpful services." It is worth noting that when mental health services were becoming established in many JDCs, generally over the past 10 years, being viewed by the NJDA as essential to the JDC's continuum of services was extremely important. In effect, this inclusive definition provided a "conceptual grounding" for professionals working in the field. In 1989, the NJDA defined juvenile detention centers as:

> providing a wide range of helpful services that support the juvenile's physical, emotional, and social development. Helpful services include education, visitation, communication, counseling, continuous supervision, medical and health care, nutrition, recreation and reading. Juvenile detention includes or provides for a system of clinical observation and assessment that complements the helpful services and reports findings [Ref. 1, pp 218–19].

The Juvenile Detention Mental Health Movement

To understand better the driving forces and dilemmas facing the juvenile justice system, we must review Grisso's discussion of the four phases of the juvenile justice and mental health movement.[3] The first phase, in the beginning of the 20th century, was marked by *parens patriae*, or a period of time when judges acted as "benevolent parents . . . figures concerned primarily with the best interest of the child" (Ref. 11, p 312). Phase two began in the 1960s and signaled a shift away from *parens patriae* and toward due process. Cases such as *Kent v. U.S.*[12] and *In re Gault*[13] were principally responsible for these changes. Phase three, beginning in the early 1990s, was born out of society's fear of the dangerous delinquent "super-predator" (Ref. 3, p 158) and often espoused the view that these youth could not be rehabilitated. This perspective, coupled with the "collapse" of the children's community mental health system, contributed to an influx of children into JDCs. Since that time, ongoing concerns have been voiced that JDCs have become places to "deposit youths" unable to receive community mental health supports.[3] A 2004 congressional study raised just this concern, noting that youth are being "warehoused" in JDCs across the country while awaiting community-based mental health services.[14] Finally, the current movement, phase four, began around 2000, and has focused on incarcerated juveniles' mental health needs. Child advocates have also been vocal that the "punitive excesses" of the super-predator phase ignored or even potentially exacerbated youths' mental health problems.[3]

Yet, while the current movement has been effective at many levels, Grisso notes that the evolution of this final phase has been rapid. As a result, the movement's evolution did not allow for a long-range blueprint, a potential vulnerability of the movement and its sustainability moving forward.[3] Further, its quick growth did not allow for careful consideration of its potential perils. As an example, Grisso suggests that the mental health treatment needs of preadjudicated detainees has been overinterpreted, resulting in the premise that each child with a DSM disorder needs psychiatric treatment during pretrial detention.[3] This faulty analysis has resulted in already overburdened, financially strapped JDCs' feeling overwhelmed and/or paralyzed at the prospect of needing to treat up to 75 percent of their total population.[3]

"Iatrogenic injustice," or "creating legal jeopardy for youths in the name of beneficence" is another peril discussed by Grisso (Ref. 3, p 165). Perhaps the best example is the implementation of the Massachusetts Youth Screening Instrument Second Version

(MAYSI-2) in various JDCs.[3] Initially, the MAYSI-2 was intended to provide a validated mental health screening on intake and was seemingly benign. Grisso reminds us, however, that judges must establish policies prohibiting the use of these screening devices in the adjudication process. When a juvenile justice system does not recognize these difficulties early in its reform efforts, the action's benefit can be lost in the name of "justice."[3] Grisso also raises the sensitive but very real concern that authority is needed to involve preadjudicated youth in treatment before adjudication. In this context, concerns arise about the obtaining of information through an unprivileged relationship and having that information later used to convict the child.[3]

"Treatment" and the Ongoing Questions Regarding Role and Mission

A subject currently debated by correctional mental health professionals is the definition of "treatment," as specifically applied to preadjudicated juveniles. Penn and Thomas's[5] work on practice parameters provides critical guidance regarding the challenges of clinical work in JDCs, including, but not limited to, intake screening, monitoring and evaluation, the role of psychotropic medications, and the complexities of the clinician's role in adapting to the JDC environment. While some mental health professionals may still see clinical interventions in time-limited, nonmilieu-based settings as inherently "less than," this type of guidance has helped many clinicians working in JDCs to see their work as merely different and even as ripe with potential benefits to detainees.

Yet, despite attempts to adapt mental health services specifically to JDCs, opinions still vary about the JDC's essential functions, as well as the emphasis that should be placed on each function within the JDC, including "helpful services."[1] Earlier in this article, we reflected on the NJDA's definition of "helpful services" including their focus on the integration of safe custody and service provision functions.[1] However, despite the sensibility of the NJDA's definition, Roush notes that the contradictory definitions of juvenile detention are still a central problem for juvenile detention administrators.[15] As evidence, he cites a study in which administrators reported that custody was the most significant function of detention.

In this context, the resolution of what Roush describes as a "paradox" in our understanding of the JDC's role and function is a necessary first step for the movement.[15] Custody and service functions must become conceptually integrated and accepted on a larger scale—as an alternative to historic "treatment versus custody" rhetoric. Without this work, JDCs run the risk of being a "place" that is merely the object or outcome of juvenile court action.[15]

Moving Forward

We no longer have to argue about whether JDCs should provide custody or therapy. Instead, they can provide both mental health services and safe custodial environments, as mandated by accreditation bodies and legal standards. National accreditation organizations support this integration of functions. For example, health care standards promulgated by the National Commission on Correctional Health Care (NCCHC) encourage interdisciplinary collaboration in health care delivery, as exemplified by their standard on special-needs treatment plans.[8] These plans involve all JDC staff, including mental health professionals, in providing individualized supports for detainees with special mental health needs.

Treatment in preadjudicated JDCs does not necessarily mean lesser care, but rather care that is carefully considered, "does no harm," and is tailored to the realities of a legally focused host environment. Apart from the high rate of mental health disorders found among detainees, we cannot forget that detainment alone is a significant stressor. While the preadjudicated JDC will necessarily maintain its primary identity as a setting to manage detainees safely before court disposition, helpful services can clearly be integrated and individualized according to detainees' needs.

It is time to build on the helpful practice parameters developed by Penn and Thomas[5] and related literature, to bring our best thinking, research, and practice together in open dialogue on the local, state, regional, and national levels. Further, in collaboration with juvenile justice administrators and judges, we can develop innovative mental health blueprints uniquely adapted to preadjudicated JDCs. The more that juvenile justice and mental health professionals collaborate in developing practical, well-integrated mental health services in JDCs and make these models available across jurisdictions, the more sustainable the juvenile justice and mental health movement will be.

The question of how we can fully operationalize this new call to action is complicated. But, given Grisso's insightful analyses, we are awakened to the fact that "sustaining the effect" of the present reform movement inevitably rests on our collective shoulders. Progress will require collaboration among correctional health care organizations; universities; local, regional, state and national municipalities; and other stakeholders. We are thankful to Grisso for showing us that the time has come.

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