



Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment and treatment of youth in juvenile detention and correctional facilities.

BIBLIOGRAPHIC SOURCE(S)

Work Group On Quality Issues. Penn JV, Thomas C. Practice parameter for the assessment and treatment of youth in juvenile detention and correctional facilities. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2004. 19 p. [42 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Mental health disorders

Substance-related disorders

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Pediatrics
Psychiatry
Psychology

INTENDED USERS

Health Care Providers
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

- To present recommendations for the mental health assessment and treatment of youth in juvenile detention and correctional facilities
- To provide clinical guidelines for child and adolescent psychiatrists working in juvenile justice settings

TARGET POPULATION

Children and adolescents in juvenile detention and correctional facilities

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnostic Assessment/Evaluation

1. Screening for the following:
 - Mental disorders
 - Substance use disorders
 - Suicide risk factor and behavior screening including:
 - Questions regarding past suicidal ideation and/or attempts
 - Current ideation, threat, or plan
 - Prior mental health treatment and/or hospitalization
 - Recent significant loss (relationship, death of family member or close friend)
 - History of suicidal behavior by family member or close friend
 - Suicidal ideation or behavior during prior confinement
 - Initiation or discontinuation of psychotropic medication(s)
 - Other emotional or behavioral problems
2. Evidence-based mental health screening
 - Massachusetts Youth Screening Instrument-Second Version (MAYSI-2)
3. Continuous monitoring for mental or substance use disorders, emotional or behavioral problems, and suicide risk
4. Use of a biopsychosocial approach with special emphasis on cultural, family, gender, and other relevant youth issues
 - Use of problem-focused brief mental health assessments, which may result in:

- "Suicide precautions"
 - Transfer to an alternate setting
 - Referral for a more comprehensive mental health evaluation
 - Other treatment recommendations
 - Comprehensive post-admission mental health assessment
 - Assessment for substance use disorders and withdrawal symptoms
 - Assessment for comorbid conditions
 - Educational evaluation
 - Psychological testing
5. Evaluation for current and future risk of violent behavior

Management/Treatment

1. Referral for further evaluation by a mental health clinician when necessary (e.g., recent/current suicidal ideation, attempts, or symptoms of a mental or substance-related disorder)
2. Selective use of restrictive procedures only when needed to maintain safety or when less restrictive measures have failed
 - Punitive restraints (restraints by properly trained direct-care staff for immediate control of behavioral dyscontrol)
 - Therapeutic restraints (restraints for youth under treatment for mental illness)
3. Use of psychotropic medications
4. Development, implementation, and reassessment of individualized treatment plans
5. Planning for re-entry into the community that incorporates multidisciplinary, culturally competent, family-based treatment approaches (discharge planning)

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
 Hand-searches of Published Literature (Secondary Sources)
 Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

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

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

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

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

[CG] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

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

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

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was reviewed at the member forum at the 2003 annual meeting of the American Academy of Child and Adolescent Psychiatry (AACAP). During July to October 2004 a consensus group reviewed and finalized the content of this practice parameter. The consensus group consisted of representatives of relevant American Academy of Child and Adolescent Psychiatry components as well as independent experts. This parameter was approved by the American Academy of Child and Adolescent Psychiatry on November 8, 2004.

A group of experts, including members of the AACAP Committee of Rights and Legal Matters and the AACAP Committee on Juvenile Justice Reform, also reviewed the parameter.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations are identified as falling into one of four categories of endorsement. These categories, which are defined at the end of the "Major Recommendations" field, indicate the degree of importance or certainty of each recommendation.

Recommendation 1: The clinician should have an awareness and understanding of the operations of the juvenile correctional facility and the issues affecting it, including the interface with multiple systems (e.g., police, probation, family/juvenile courts, social services, and child welfare agencies) and the existing educational and health care systems within the facility [CG].

Orientation and continuing education activities designed for juvenile correctional facility staff should include training across child service agencies or areas including

correctional, educational, health, mental health, and juvenile court. Mental health clinicians benefit from training and orientation by the security staff in the correctional setting, including such matters as social order, gang affiliations, and attitudes toward sexual offenders. Similarly, cross-training can improve the correctional staff's understanding of juvenile's suicide risk factors, psychopathology, and early development, including the sexual and psychological domains. Facility personnel can provide perspective on youths' utilization and manipulation of the mental health professional and system.

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

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

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

Recommendation 2: All youth entering a juvenile justice detention of correctional facility should be screened for mental or substance use disorders, suicide risk factors and behaviors, and other emotional or behavioral problems [MS].

Generally, youth undergo mental health screening during the first 24 hours of incarceration. In addition, National Commission on Correctional Health Care (NCCHC) standards require a post-admission assessment of all juveniles with positive screens within 14 days of admission.

Upon arrival at a juvenile justice facility, youth should undergo systematic mental health screening by trained correctional staff and qualified health care professionals. To respond effectively to the high prevalence of mental health and substance abuse problems among incarcerated youth, the intake process should include comprehensive screening for suicide risk, alcohol and other illicit drug abuse, and adjustment to the juvenile justice setting. Policies and procedures regarding referral of youth to mental health or medical personnel should be in

place. Intake screening for suicide risk should include questions regarding past suicidal ideation and/or attempts; current ideation, threat, or plan; prior mental health treatment and/or hospitalization; recent significant loss (relationship, death of family member or close friend); history of suicidal behavior by family member or close friend; suicidal ideation or behavior during prior confinement; and initiation or discontinuation of psychotropic medication(s).

An evidence-based mental health screening should be undertaken as part of the general health screen. One instrument specifically developed to assess youth in the juvenile justice system is the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), a brief 52-item self-report questionnaire. The MAYSI-2 is intended primarily for use at the front door of juvenile justice systems by nonclinical staff to identify youth who may be in need of immediate clinical intervention. The MAYSI-2 shows promise as a reliable and valid screening tool to assist juvenile justice staff in identifying youth who may need immediate response and further clinical assessment of potential mental or emotional problems.

Recommendation 3: All youth held in a juvenile justice detention or correctional facility should receive continued monitoring for mental or substance use disorders, emotional or behavioral problems, and especially for suicide risk [MS].

In view of the high prevalence of mental disorders and the high incidence of suicidal behavior in youth in juvenile correctional facilities, every juvenile justice facility should have a suicide prevention program for identifying and responding to each potentially suicidal youth. It is therefore necessary for youth held in detention or correctional placements to receive continued monitoring and repeated assessment for emotional or behavioral problems during confinement. Two essential components of a successful suicide prevention program are properly trained staff and ongoing communication between direct-care personnel and clinical staff. Continued observation and re-assessment is particularly important in the prevention of suicide for detained youth. The American Psychiatric Association (APA) Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons has identified some high suicide risk periods for incarcerated adults and has recommended several key components for an adequate suicide prevention program. While a youth may become suicidal at any point during incarceration, particularly high-risk periods include initial detention, transfer for court appearance, return to the correctional facility, sentencing, receipt of new legal problems, receipt of bad news, feelings of humiliation or rejection, confinement in isolation or segregation, and a prolonged stay in the facility. Youth with mental and substance-related disorders may pose an even higher suicide risk during any of these periods.

Any youth who engages in self-mutilative behavior, even if believed by staff to be manipulative or a gesture for secondary gain, warrants prompt evaluation by a health care professional: (1) to assess whether additional medical treatment (e.g., debridement, suturing, wound care, bandaging) is needed, (2) to clarify whether direct-care staff interventions and special levels of observation are required, (3) to initiate evaluation by a qualified mental health professional, and (4) to determine whether urgent psychiatric consultation is indicated. Youth who ingest medications or foreign objects or engage in more violent or potentially lethal

behaviors (e.g., stabbing, hanging, etc.) will likely require emergency medical evaluation.

Recommendation 4: Any youth with recent/current suicidal ideation, attempts, or symptoms of a mental or substance-related disorder during the period of incarceration should be referred for further evaluation by a mental health clinician [MS].

After the intake process, should any staff hear a youth verbalize a desire or intent to commit suicide or hear about such a desire or intent from other staff or residents, observe a youth engaging in any self-harm, or otherwise believe a youth is at risk for suicide, a procedure should be in place that requires staff to take immediate steps to ensure that the resident is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained.

Recommendation 5: Clinicians working in juvenile justice settings must be vigilant for personal safety and security issues and aware of actions that may compromise their safety and/or the safety and containment of the incarcerated youth [MS].

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

Recommendation 6: All qualified mental health professionals should clearly define and maintain their role as clinician to youthful offenders and their family members [MS].

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

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

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

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

Recommendation 7: Adequate time and resources are needed to perform a mental health assessment of incarcerated youth utilizing a biopsychosocial approach with special attention to cultural, family, gender, and other relevant youth issues [CG].

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

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

All evaluations of youth in juvenile justice settings require an assessment for substance use disorders and withdrawal symptoms because of the high percentage of youth with this problem and the association of recidivism and substance use problems in this population. Clinicians should work together with medical staff to enable facilities to intervene early in assessing and treating

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

A complete developmental, social, and medical history is a part of any comprehensive assessment involving adolescents. Clinicians should attempt to gather relevant collateral information whenever possible from family members; clinical, educational, and correctional staff; previous service providers; treatment records; and educational records. It should include an assessment of the youth's strengths and available resources in addition to any problems and deficits. This information will be instrumental in identifying the youth's past behavioral patterns, prior level of functioning, adaptation to incarceration, disruptive or problematic behaviors, interaction with peers and staff, and overall level of impairment, adjustment, and functioning in a correctional unit setting. All newly incarcerated youth require educational evaluations and, upon adjudication, will require an individualized treatment plan utilizing the multidisciplinary role of educators and clinicians. It is helpful for the clinicians and educational personnel to communicate because ongoing communication between clinicians and educators enhances both treatment and education. Some youth may already have a previous special education designation with an individualized education program, which should be implemented in the facility. Also, some youth may benefit from additional evaluations, including psychological testing; specialized educational, speech, and language assessment; occupational or physical therapy evaluation; or additional specialized assessments such as evaluation for substance abuse, fire setting, and sexual offender or neurological consultation. When performing any type of mental health evaluation of an incarcerated youth, it is critical for clinicians to utilize a biopsychosocial model with attention to unique adolescent developmental, peer, gender, cultural, religious, and family issues. Clinicians should also evaluate for histories of trauma, peer and family relationships and functioning, and family psychopathology, including domestic violence, physical and sexual abuse, and family criminality, substance abuse, or mental illness. A detailed assessment of the youth's past exposure to violence and perpetration of violent or illegal behaviors is essential. Clinicians should also carefully elicit any history of high-risk behaviors - unprotected intercourse, promiscuity, multiple partners, gang activities, prostitution, running away - and comorbid eating, somatoform, and gender identity disorders.

Recommendation 8: Clinicians should be alert for symptoms, behaviors, and other clinical presentations of malingering, secondary gain, and manipulative behaviors by incarcerated juveniles [CG].

Clinicians should be aware that some psychiatric symptoms such as hallucinations, delusions, physical complaints, self-mutilative behaviors such as actual or attempted ingestion of chemicals or foreign objects, superficial cutting, or other actual or threats of self-injury may be attempts to avoid incarceration or to be placed into a perceived less restrictive and more therapeutic environment (e.g., medical or psychiatric hospital) or alternatively a nonsecure setting for possible elopement. Although structured interviews and additional psychological testing may be helpful, the mainstay of diagnosis remains a high index of suspicion

combined with careful data collection and ongoing assessment for discrepancies in historical information and for clinical inconsistencies in the mental status examination. It is important to collect collateral information when suspicions of malingering arise; staff observations are particularly invaluable. This additional information will help to identify inconsistencies and discrepancies commonly found in adolescent malingerers.

Recommendation 9: All clinically referred youth should be evaluated for current and future risk of violent behavior [CG].

Exploration into the youth's violence history should include such variables as how chronic or recent, as well as the frequency, severity, and context of violent behavior. The clinician should clarify the youth's history of exposure to domestic violence, past physical and sexual abuse and other traumatic events, perpetration of violence against others (e.g., cruelty to animals, bullying, fire-setting, sexual assaultive behaviors), substance abuse, and other risk factors for future violence. In addition, a standardized approach should be used to elicit a history of weapon possession, access to and use of weapons pre-incarceration, and assaultive or threatening behaviors against peers or staff prior to or during incarceration.

Recommendation 10: Mental health professionals should be aware of unique therapeutic and boundary issues that arise in the context of the juvenile correctional setting [CG].

Aside from maintaining issues of personal safety and security, clinicians should be attuned to youth, family, institutional staff, and clinician interactions and relationship issues and should strive for clearly defined therapeutic clinical boundaries with incarcerated youth, families, and staff.

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

Recommendation 11: Clinicians should be knowledgeable about the facility's policies and procedures regarding seclusion, physical restraints, and psychotropic medication, and in support of humane care should advocate for the selective use of restrictive procedures only when needed to maintain safety or when less restrictive measures have failed [CG].

Clinicians should be especially careful to avoid the use of psychotropic medications for staff benefit. Clinicians should have knowledge of current institutional seclusion and restraint policies and procedures. Generally, current national standards require written institutional or department policy and defined procedures for the appropriate use of therapeutic restraints for patients under treatment for a mental illness. The NCCHC, the American Correctional Association, and other national organizations that develop health care standards for correctional facilities have created and promulgated national guidelines and standards for the use of punitive (restraints by properly trained direct-care staff for immediate control of behavioral dyscontrol) versus therapeutic restraints

(restraints for youth under treatment for mental illness) in juvenile correctional facilities. They specify the types of restraint that may be used and when, where, how, and for how long restraints may be used. A physician, or other qualified healthcare professional as allowed by the state health code, authorizes the use of therapeutic restraints in each case upon reaching the conclusion that no other, less restrictive treatment is appropriate. Physicians should use caution and discretion in using restraints in youth with histories of sexual abuse and be vigilant about the risk of airway obstruction with prone restraints and/or excessive pressure on a youth's back. For restrained patients, the treatment plan addresses the goal of removing the juvenile from restraint as soon as possible. The health care staff does not participate in the nonmedical or punitive restraint of incarcerated juveniles except for monitoring their health status

Recommendation 12: Clinicians should use psychotropic medications in incarcerated juveniles in a safe and clinically appropriate manner and only as part of a comprehensive treatment plan [CG].

If psychotropic medications are used, they should augment a comprehensive and individually developed mental health treatment plan with the youth's compliance and active participation including the modalities of individual, group, and family therapy and other appropriate treatment interventions. Clinicians can also recommend the implementation of behavioral interventions and strategies such as regular exercise and improved sleep hygiene, encouragement of available family members and other social supports to rally around an incarcerated youth, facilitation of additional staff supervision and support, development of additional supportive relationships with both peers and direct-care staff, and use of other correctional, clergy, and community resources.

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

Issues that are particularly relevant with detained youth include weighing the risk/benefit of the proposed psychotropic medication: the medication's risk in overdose, side effects, anticipated youth and family compliance with medication and follow-up treatment, prescription coverage and health plan benefits, and the potential for diversion (e.g., psychostimulants). The youth's clinical treatment team should reassess the need for previously prescribed psychotropic medications on the basis of current symptoms, level of functioning, and treatment needs.

Clinicians and direct-care staff must be aware of the potential abuse of psychiatric medications, as well as trading medication for money or sexual favors or its use

as barter goods. Clinicians should educate nursing staff, other clinical staff, and direct-care staff when appropriate and should review the evaluation and management of medication noncompliance, including surreptitious behaviors such as "cheeking" medications. Finally, clinicians should assess youth's medication compliance and perform ongoing follow-up and monitoring for the emergence of problematic side effects. It is important for clinicians to explore the circumstances and rationale for a youth's pattern of medication refusal with the youth, clinical team, other relevant staff, and the youth's family when indicated.

Recommendation 13: Clinicians should be involved in the development, implementation, and reassessment of the youth's individualized treatment plan while in the correctional setting and with the planning process for re-entry to the community that best incorporates multidisciplinary, culturally competent, family-based treatment approaches [CG].

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

Recommendation 14: It is paramount for clinicians working in juvenile justice settings to be aware of relevant financial, fiscal, reimbursement, agency, and role issues that might affect their ability to provide optimal care to incarcerated youth and consultation to the juvenile correctional system [OP].

Clinicians should have an understanding of (1) the existing or proposed infrastructure and payment/reimbursement model for mental health evaluation and treatment delivery; (2) various roles and responsibilities (caseload, expected daytime availability, after-hours and emergency coverage); (3) volume of referrals and amount of time per evaluation, collateral contact, and follow-up evaluations; (4) any expectations regarding training and supervision of other mental health or correctional staff; and (5) any financial or other administrative constraints that might limit or ration appropriate treatment and care and thus increase medicolegal and other liability issues.

Clinicians should be aware that the same professional standards and most of their state regulations pertaining to clinical practice apply to the services they provide in juvenile correctional settings.

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

Society of Correctional Physicians, and the National Commission on Correctional Health Care.

Definitions:

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

[**CG**] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

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

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

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated. In general, the recommendations were based on evaluation of the scientific literature and relevant clinical consensus.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate assessment and treatment of mental and substance-related disorders of youth in juvenile detention and correctional facilities

POTENTIAL HARMS

Issues that are particularly relevant with detained youth include weighing the risk/benefit of the proposed psychotropic medication: the medication's risk for overdose, side effects, anticipated youth and family compliance with medication

and follow-up treatment, prescription coverage and health plan benefits, and the potential for diversion (e.g., psychostimulants).

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

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

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Work Group On Quality Issues. Penn JV, Thomas C. Practice parameter for the assessment and treatment of youth in juvenile detention and correctional facilities. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2004. 19 p. [42 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Quality Issues

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

This parameter was developed by: Joseph V. Penn, M.D., and Christopher Thomas, M.D.

Work Group Members: William Bernet, M.D. (Co-Chair); Oscar G. Bukstein, M.D. (Co-Chair); Valerie Arnold, M.D.; Joseph Beitchman, M.D.; R. Scott Benson, M.D.; Joan Kinlan, M.D.; Jon McClellan, M.D.; Jon Shaw, M.D.; Sandra Stock, M.D.

AACAP Staff: Kristin Kroeger Ptakowski

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format from the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site](#).

A CD-ROM containing all parameters is available for a fee. See the [AACAP Publication Store](#) for more information.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on April 1, 2005.

COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions. Any reproduction, retransmission, or republication of all or part of the original guideline is expressly prohibited, unless AACAP has expressly granted its prior written consent to so reproduce, retransmit, or republish the material. All other rights reserved.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at <http://www.guideline.gov/about/inclusion.aspx>.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2008 National Guideline Clearinghouse

Date Modified: 9/15/2008

