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## Crisis Intervention Services in Juvenile Detention Centers

The prevalence of mental disorders among juvenile detainees is estimated to be as high as 60 percent, and reports suggest that adolescents who are detained have a three- to fourfold risk of suicide. The transfer of juveniles who commit serious offenses to the adult legal system and the problems of overwhelmed child care agencies appear to have precipitated a shift in the composition of populations in juvenile detention centers. Adolescents are often detained for minor legal charges that occur in the context of severe behavioral problems and family stress. We report on a collaborative venture between a state juvenile justice system and the psychiatry department of a medical school for assessing and intervening with acutely distressed youths.

The program was implemented for short-term juvenile detention centers where youths are held pending adjudication of their cases, usually for two to four weeks. The high turnover in such centers means that the staff are less familiar with individual youths and thus makes the need to assess suicide risk compelling. During admission, youths complete a self-report suicide scale that is integrated into the standard intake protocol. Detention center staff are trained to administer and score this instrument and to probe for information specifically pertaining to psychiatric history, including suicidal ideation and intent. Because suicide watch status becomes part of the computerized record as an incident report, information on concerns about suicide risk during previous detentions is available. Detainees are automatically placed on suicide watch if any risk factor is identified during intake, and they remain under watch until evaluated by the mental health consultant.

A licensed mental health consultant from the psychiatry department—usually a psychologist or a social worker—is on-site at each detention center for three hours a day, five days a week. The consultant's role is to determine severity of symptoms, to fa-

cilitate psychiatric hospitalization when indicated, and to make referrals to a consulting psychiatrist, who is onsite for three hours on one day of each week at each site. The psychiatrist evaluates and monitors ongoing psychotropic medication prescribed before admission. Because adequate follow-up is requisite for good care, psychiatrists typically do not initiate medication except when acutely indicated, in which case an inpatient referral is usually called for.

Detention center staff undergo intensive training by a nurse practitioner in medication administration and documentation. Standard administration times are adjusted to avoid scheduled dosing during shift changes. The consulting psychiatrist is on call to approve medications for newly admitted youths and to advise staff how best to respond to adverse reactions or other acute situations. For behavioral concerns, the mental health consultant is usually contacted first, whereas the consulting psychiatrist is contacted for medication concerns.

Case managers are employed by the detention centers to monitor the well-being of detained youths. They conduct psychosocial assessments, including detailed social, legal, medical, and psychiatric histories, by using standardized forms and make disposition recommendations to the court. They work closely with the mental health consultant to triage youths who need further assessment. The level of observation that youths are assigned to receive is tailored to the degree of risk: suicide alert (15minute checks), suicide watch (fourminute checks), and constant observation (continual direct observation by an assigned staff member). In most cases, youths who receive constant observation are in acute enough distress to warrant psychiatric hospitalization. In these instances, the mental health consultant contacts the admissions office of a local hospital to arrange precertification from the appropriate third-party payer.

The most common inpatient interventions include assessment, stabilization, and medication evaluation. Concerns about disposition, danger-

ousness, and severity of legal charges frequently need to be addressed during the referral process. Our program provides outreach and education to hospitals that accept referrals to prepare hospital staff to effectively manage these youths and develop appropriate policies—for example, keeping youths on a locked unit. Hospitalization policies and procedures are approved by superior court.

As a general rule, the mental health consultants do not communicate directly with the court. Other mental health professionals are contracted by the detention centers for forensic evaluations. After a hospitalization, the mental health consultant facilitates communication between the hospital clinician and the detention center case managers (after appropriate consents are obtained), and the case manager brings the information to all parties in the court when appropriate and relevant. These boundaries have proven essential to ensuring that the efforts of the mental health consultants are focused on the immediate needs of the youth.

This collaborative program has been in operation for several years. The program recognizes the mental health needs of adolescents in detention centers and has increased staff awareness of suicide and psychiatric problems. The clinical assessments help to address behavioral problems during detention and help case managers to make disposition recommendations. Several hospitalizations occur each month, demonstrating the need for this service, and detention center staff have become more interested in mental health education and training as the program has matured.

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