Mental Health Care of Detained Youth Within Juvenile Detention Facilities

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KEYWORDS

• Mental health treatment • Juvenile justice • Juvenile detention
• Trauma-informed care • Solitary confinement • Isolation • Seclusion

KEY POINTS

- Youth in the juvenile justice system have a high prevalence of a diverse array of mental disorders and severe psychosocial stressors.
- Trauma is common, and trauma-informed care should be considered a universal precaution in working with justice-involved youth.
- Youth can benefit significantly from evidence-based psychosocial and pharmacologic interventions.
- Although clinically ordered and supervised seclusion may be appropriate in limited situations, disciplinary or punitive use of isolation or solitary confinement is categorically inappropriate.

INTRODUCTION

Mental health treatment of juvenile offenders and undocumented immigrant youth in detention provides a unique opportunity for treatment providers. Although the work may be challenging, the clinical needs and opportunities for early and meaningful interventions are significant. Adjudication "is the court process that determines (judges) if the juvenile committed the act for which he or she is charged. The term 'adjudicated' is analogous to 'convicted' and indicates that the court concluded the juvenile committed the act."[1] Common causes of youth adjudication include violence directed

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at others, vandalism, burglary or robbery, status offenses including curfew violation, loitering or disorderly conduct, truancy, running away, underage drinking, trespassing, weapons offenses, drug abuse violations, and driving under the influence. Less common reasons for adjudication include aggravated assault, homicide, manslaughter, arson, gambling, embezzlement, forgery, counterfeiting, prostitution, obstruction of justice, and sexual deviance.

Many reasons for the adjudication of youth exist. Often the youths' causes for adjudication are complex: comorbid psychosocial conditions and stressors are common. Youthful offenses are frequently influenced by poverty, disenfranchisement, poor access to jobs, residential segregation, schools ill-equipped to address acting-out behaviors, family structure including single-parent households and family disruption or a parent in prison, substance use, mental health disorders, and so forth. Community level structural factors impede systemic social organizations and often impede living within the constraints of the law.[2]

Mental health care of youth in the juvenile justice system and asylum-seeking youth in detention provides a unique opportunity to address and remedy social constraints in the context of psychiatric illness. Adjudicated youth and undocumented immigrant youth have significantly higher rates of mental illness than youth in the general population.[3] The prevalence of mental health disorders in adjudicated youth in nonresidential facilities is estimated to be 50%.[4] Asylum seeking youth were often exposed to violence and as a result seek residence in another country. The prevalence of mental illness among youth involved in the juvenile justice system located in residential treatment facilities is estimated to be between 65% and 70%.[4] Youth in the juvenile justice system can have any illness within the spectrum of mental illness. Behavioral disorders such as conduct disorder are the most frequently diagnosed mental illnesses in adjudicated youth at 62% for male youth and 48% for female youth.[4] Substance use disorders occur in 46.2% of adjudicated youth.[4] According to Wasserman and colleagues, anxiety disorders are estimated to affect 34.4% of youth in the juvenile justice system,[4] and 18.3% of adjudicated youth have mood disorders.[4] Reportedly, 10.6% of male youth and 29.2% of female youth have clinical depression.[5] Attention-deficit/hyperactivity disorder prevalence is measured at 21% for male youth and 24% for female youth.[5] In addition, it is estimated that up to 19% of detained youths are suicidal during detention, and approximately 50% of female youth in the juvenile justice system have symptoms of posttraumatic stress disorder (PTSD).[5] It is common for youth to have more than one mental disorder. When conduct disorder is removed as a possible mental disorder in adjudicated youth, 66.3% of youth meet criteria for a mental disorder.[6] The problems adjudicated children face are diverse. Each child's social and mental health needs are unique. Despite the heterogeneity of the problems faced by adjudicated youth, mental health treatment has been shown to reduce recidivism rates by 25% compared with children who are not treated for psychiatric illness.[7] The most successful programs have reduced recidivism rates by 25% to 80%.[8]

PRINCIPLES OF ADJUDICATED YOUTH MENTAL HEALTH TREATMENT

When possible, diversion to community-based, integrated mental health services is preferable to incarceration. When these less-restrictive resources have been exhausted and adjudication and further juvenile justice involvement is mandatory, youth should have access to evidence-based medical treatments.[9,10] Although involvement in juvenile court may grant access to mental and physical health treatment, social services, family-based services, and educational services that would otherwise not be available, entrance to the juvenile justice system should not be

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motivated by increasing access to these services. Entry into the juvenile court system itself may exacerbate underlying mental health conditions due to overcrowding, lack of appropriate treatment, restrictive housing, separation from support systems, and other potential traumas.[9]

Services provided by the juvenile justice system should be child and family focused, culturally competent, and developmentally appropriate. Mental health services should be equipped to respond to issues of gender, ethnicity, race, age, sexual orientation, socioeconomic status, and faith.[11] When possible, families should be made active participants in their child's mental health treatment. Families who are equipped with information about the process of justice involvement and treatment can serve as strong advocates and support systems for their child while navigating these systems.[11] Mental health treatment providers should ideally collaborate with all systems of care to create a unique and individualized treatment approach. Equally important is the training of law enforcement and juvenile justice staff to interact with youth with behavioral health conditions in a way that is trauma informed and strengths based.[11]

The National Mental Health Association identified a series of values and principles inherent to the care of children in the juvenile justice system in the publication *Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices* (2004):[12]

- Early identification and intervention are vital to promoting positive outcomes. Children must have access to a comprehensive array of individualized formal and informal services that address their physical, emotional, social, and educational needs. Services should be delivered in the least restrictive, normative environment that is clinically appropriate.
- Families and caregivers should be full participants in all aspects of policy development and the planning and delivery of services, which should be integrated with linkages between child and family serving agencies and programs.
- Care coordination should be provided to ensure that multiple services are linked and clinically indicated. They should also address a family's strengths and needs and be reviewed on a regular basis for applicability to the family's current level of functioning.
- The service delivery system should include providers who help enable smooth transitions to adult services, if necessary.
- The rights of children should be protected and effective advocacy efforts should be promoted.
- Services must be provided without regard to race, religion, national origin, sex, physical disability, or similar characteristics.

Recent changes in the juvenile justice system emphasize a public health–based model of care that is a more rehabilitative and strengths-based model in which youth are viewed as having the potential for positive growth.[9] The needs of justice-involved youth and their families are complex and cannot be adequately addressed by one universal approach. Done well, comprehensive and collaborative mental health services within the juvenile justice system reduce recidivism and lead to decreased future juvenile justice involvement, with the hope of positively affecting individual and family functioning.[12]

TRAUMA ISSUES IN JUVENILE JUSTICE

Numerous studies have identified high rates of PTSD and trauma in adjudicated youth, with trauma history considered a risk factor for eventual involvement in the juvenile

court system.[13,14] Sexual trauma is considered a major risk factor for female youth, particularly female youth of color.[15] Trauma may include experiences while in placement or foster care, including physical or sexual assault or witnessing the assault of other youth, as well as traumatic losses and victimization in the community. Repeated traumatization is common, and one study identified that 5% of incarcerated youth have had 11 or more major traumatic experiences.[14] "Complex trauma," referring to exposure to traumatic stressors that compromises secure attachment and the ability to self-regulate emotions, is common among incarcerated youth.[16] Complex, chronic, and early childhood traumas can also have profound impacts on subsequent neurodevelopment and functioning.[17,18]

Trauma-related symptoms may be misinterpreted as symptoms in need of disciplinary intervention by criminal justice professionals. For example, exaggerated startle responses may be construed as aggression, and dissociative freezing may be seen as noncompliance.

Trauma-focused treatment is generally recognized to be most effective when it occurs in a stable, safe therapeutic setting.[19,20] Effective treatment of trauma involves medications and psychotherapy and should occur in the context of a therapeutic relationship that is stable and experienced as safe for the consumer. One of the most significant limitations of trauma work in juvenile justice settings is the stability of the therapeutic relationship. A therapeutic context is more challenging to achieve in many juvenile justice settings, often jeopardized by lack of clinical control over length of treatment or the environment of care. The therapeutic relationship may be further challenged by the youth's reluctance to disclose traumatic experiences involving criminal conduct of the youth or others.[21]

CRISIS MANAGEMENT OF YOUTH IN DETENTION CENTERS

In addition to all of the intrinsic psychosocial risk factors that justice-involved youth live with (and which may well have predisposed them to justice involvement), the detention process itself can be stressful. Detention centers need to be able to balance facility security needs with compassionate, calming interventions that can deescalate youth and support them through the criminal justice process. Even for a youth with a relatively pristine prior mental health history and substantial social supports, the process of detention and proceeding through the justice process can be extremely distressing. Finally, failure to adequately manage underlying psychiatric disorders (eg, ongoing medication management, coordination with other treatment providers) can lead to acute decompensation as well.

Newly detained youth may be apprehensive about the new setting and may have acute psychosocial stressors. Further, suicidal thoughts, recent suicidal behavior, and current passive death wish or hopelessness are common in incarcerated youth and are spontaneously reported only half of the time.[22]

When adapting clinical strategies for agitation and acute crisis management to juvenile justice settings care must be taken. Fundamental strategies such as deescalation and consideration of underlying medical and psychiatric contributions to agitation remain critical.[23–25] However, clinicians need to recognize that justice setting may lack common safeguards that are used in managing agitation in clinical settings, including availability of a nurse to monitor vital signs or medical issues, routine observation during seclusion, justifications for initiating and ending physical interventions, or even the simple matter of notifying the psychiatrist of the incident. Establishing clear policies in alignment with clinical ethics and standards from groups such as the National Council for Correctional Health Care is important. Strategically, and with any

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intervention for agitation, underlying causes need to be addressed. Biological interventions—and for that matter, restraints and holds—will do little to mitigate underlying contextual stressors and contributors to crisis and agitation.[25]

Intake processes should include steps to identify prior psychiatric history as well as routine screening to identify previously unrecognized pathology. Adequate and ongoing training and supervision of staff for recognizing and managing distress and agitation—with an emphasis on promoting prevention and verbal deescalation over physical interventions—should be supported. Whenever possible, evaluation, screening, and supportive interventions should occur routinely and as early as possible in the detention process: it is much safer for youth and staff alike to prevent crises than to respond to them.

Notably, improved management of behavioral crises in the community may play a critical role in reducing entry into the criminal justice system. There has been increased recognition of the impact of systemic bias, police response to behavioral emergencies, and criminalization of psychosocial illness and crisis.[26] Joint law enforcement/behavioral health community crisis response teams have existed for 30 years.[27] There is growing evidence that they improve the ability to divert people with primarily mental health concerns out of the criminal justice system.[28]

TREATMENT OF DISRUPTIVE, IMPULSE CONTROL, AND CONDUCT-RELATED DISORDER IN DELINQUENT YOUTH

Disruptive, impulse control, and conduct-related disorders are of particular concern in juvenile justice settings. Almost by definition, most youth entering the juvenile justice system have some pattern of behavior that threatens the physical, financial, or emotional welfare of others. It is common for youth to enter the legal system after committing acts of battery, assault, vandalism, or other acts that jeopardize the rights of others. If there is a pattern of aggressive, deceitful, dangerous, or difficult behavior that violates social norms and creates conflict with individuals in a position of authority, a diagnosis of disruptive, impulse control, and conduct disorder should be considered.[29]

Treating disruptive, impulse control, and conduct disorders often proves challenging. Research shows that children with significant disruptive behavior benefit from skills-based interventions[30]; parenting/teacher skills training; individual, family based, and group therapy; and behavioral therapy to improve peer interactions and compliance with requests from authority figures.[31] Multisystemic therapy and behavioral therapy should focus on problem-solving skills and social competence through the utilization of community supports and positive community and family attributes.[32] When family involvement in treatment is not an option, youth require enhanced social skill training, which includes social skills acquisition, vocational training, academic assistance and direction, and life skills acquisition.[32]

Any youth who is noncompliant with treatment and repeatedly places others at risk of harm, even if the risk of harm is mild, should be considered for treatment in a residential treatment facility. Adequate residential facility treatment entails a multiple-phase program. Successful residential treatment programs are often cognitive behavior therapy focused and include, but are not limited to, (1) social skill training, (2) anger management, and (3) moral reasoning. Each phase is multipronged. The programs average around 10 weeks in duration but can take up to 2 years to complete, especially if the child has a severe pattern of conduct disorder behavior or low intelligence quotient.

In addition to behavioral therapy, family therapy, and treatment in a residential treatment facility, there is evidence that medications improve symptoms of disruptive,

impulse control, and conduct disorders.[33] At present there are no US Food and Drug Administration–approved medications to help guide treatment in this population.

There can be several barriers to "ideal" clinical care for adjudicated youth. In an ideal world, for example, a child psychiatrist can match evidence-based treatments to clear diagnoses with minimal comorbidity established by extended evaluation and adequate collateral and follow the patient over an extended, longitudinal course. Youth involved in the justice system, however, are marked by a convergence of risk factors and complicating issues: comorbidity is high, courses of treatment interrupted and fractured, psychosocial and historical risk factors prominent, and collateral often lacking. They are embedded in a system where, as so much else, race seems to determine many factors including diagnosis.[34] Further, the active family involvement that can be critical in the care of any psychiatrically ill youth is often impaired—either by the prominent psychosocial stressors affecting the families themselves or the pattern of repeated placements away from the family. Finally, youth and informants may have any number of different motivations to exaggerate, minimize, or fabricate symptoms as explanations for criminal behavior, justifications for shifting the level of care, or simply to obtain medications for their sedating or stimulating effects.

Although therapy may be a treatment of choice for many mental health disorders, adjudicated youth are often transient, presenting challenges for treatments requiring multiple sessions. For some adjudicated youth, consistent therapy is not an option and medication management may be easier to sustain than consistent talk therapy, although entering either course of treatment is fraught with some degree of risk. Several issues may be considered when deciding on medication management in this context (**Box 1**). State laws vary significantly on rules for consent to medication treatment of minors, and some states make additional qualifications for medication treatment of youth in juvenile justice settings.[35]

SECLUSION, ISOLATION, AND SOLITARY CONFINEMENT

Although seclusion and isolation may seem as similar concepts, they have distinct meanings in the context of juvenile correctional care. Seclusion and restraint are clinical interventions; isolation and solitary confinement are disciplinary measures. The National Commission on Correctional Health Care permits clinically indicated seclusion or restraint within narrow parameters but no longer allows isolation or solitary confinement.[36]

Box 1
Issues considered by prescribers before initiating or adjusting medication in adjudicated youth

- How certain is the diagnosis?
- How good is the evidence for a given medication for that diagnosis? Is the youth willing to continue to take the medication, even across placements? Are the parents or legal guardians in agreement with medication? What are the legal parameters for consent, given the age of the patient and the patient's legal status?
- Are there significant risks if the medication is suddenly discontinued due to a poor transition in care between placements or going on the run?
- If a medication is being added, changed, or removed, is the psychiatrist reasonably likely to have an adequate opportunity to monitor the patient for the effect of those changes?

In short, what are the risks of treatment and nontreatment in a correct-diagnosis or an incorrect-diagnosis scenario?

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Seclusion is the use of a separate physical space for a youth because of acute psychiatric symptoms that cannot be otherwise controlled through less restrictive means and serves as a therapeutic intervention at the direction of a physician in response to psychiatric symptoms creating imminent danger to a patient or to others. The purpose of seclusion is management of agitation and prevention of harm. Seclusion is time limited and is monitored, initiated, and ended based on clinical criteria and real-time assessment. Seclusion and therapeutic physical holds may be clinically and ethically appropriate in some limited situations in juvenile justice settings.

In contrast, isolation and solitary confinement are disciplinary interventions that are intended to be punitive or used to address security concerns. Isolation and solitary confinement generally allow little to no contact with any people except for facility staff and are not seen as being therapeutic. Such conditions can be very harmful to the well-being of the isolated person and raise significant ethical concerns. The American Academy of Child and Adolescent Psychiatry issued a policy statement in 2012 that permits the use of therapeutic seclusion in accordance with relevant laws and regulations but strongly discourages the use of solitary confinement or isolation and categorically disapproves of any seclusion or isolation greater than 24 hours.[37] Guidance on prohibited practices relating to isolation and solitary confinement for juveniles is an ongoing project of the American Civil Liberties Union (extensive resources available at <u>https://www.aclu.org/report/alone-afraid</u>). Any use of seclusion, restraint, isolation, or solitary confinement should occur in accordance with written and reviewed policies maintained by the facility and that are in alignment with relevant federal and state regulations, laws, and ethical standards.

Insofar as appropriate clinical, regulatory, and policy standards are followed, use of clinical seclusion and restraint may be appropriate in some circumstances. However, clinicians should be mindful that they may be asked to support or condone the correctional staff's use of isolation or other punitive or security interventions even when those interventions are clearly not clinically driven. In addition, there are, inevitably, many cases that are complex and ambiguous. Clinicians are encouraged to seek consultation for any ethically challenging decision and avoid lending support to questionable practices. New resources from national professional associations have recently been released to mitigate the use of seclusion and isolation in juvenile justice settings.[38]

Seclusion Considerations in the Setting of Covid-19

In spring 2020, the coronavirus-19 was declared a global pandemic by the Centers for Disease Control and Prevention. In the months following, juvenile correctional facilities began using isolation as a health precaution, given the difficulties of maintaining social distancing in facilities.[39] Although the use of isolation is nonpunitive, the literature has equated isolation for the purposes of health precautions to solitary confinement. Solitary confinement is known to have psychological effects on youth, including worsened depression, anger, obsessive thoughts, paranoia and psychosis, and elevated risk of suicide.[39] This isolation has been exacerbated by restrictions on in-person visits, both within the facilities themselves as well as with regard to interstate travel. There is no literature available at this time regarding the effects of the pandemic on the overall physical and mental health of adjudicated youth, as it relates to isolation and confinement.

DISCRIMINATION, MENTAL HEALTH, AND ADJUDICATED YOUTH

Racism is a complicated and common problem within society. Because of police brutality toward black individuals and the overrepresentation of minorities in the legal system in the United States the American Psychological Association (APA) classified

racism as a pandemic. Research has repeatedly documented racial disparities in the health care and the legal system. The consequences of racism and sexism affect the health status of children, adolescents, and their families not only in general but also in detained youth. Implicit and explicit racial and sexual biases influence acute stress, anxiety, PTSD, compulsive behaviors, obsessive thinking, low self-esteem, truancy, increase in high school dropout rates, somatic complaints, heart disease, obesity, diabetes, hypertension, and generalized poor physical and mental health.[40] Research also indicates minorities are less likely to seek mental health services due to perceived biases by health care providers, negative experiences during mental health treatment, and discriminatory practices by health care providers.[40]

The juvenile detention system is not immune to racial and sexual discrimination. Two examples of discrimination in the juvenile detention system include the overrepresentation of black youth placed in solitary confinement and the overcriminalization of lesbian, gay, bisexual, and transgendered youth. Race has a prominent role in the discretionary decision to place minority adolescents in solitary confinement. Black youth have a 68.8% greater odds of placement in solitary confinement in juvenile detention than youth of other races after controlling for variables.[41] LGBT adolescents experience higher rates of adjudication and detention for nonviolent crimes than any other demographic of youth.[42]

Resolving discriminatory practices within juvenile detention and health care is complicated. To adequately address prejudice in juvenile detention, treatment providers and institutions must recognize their own biases and discriminatory practices. For example, an inpatient child and adolescent hospital may place black youth with older children due to false perceptions of violence or age. Institutional leaders must proactively seek methods to improve mental health care by providing professional education at the institutional and individual level that addresses racial disparity. Individual treatment providers must recognize racial prejudices and actively address the potential consequences. In order to address racial disparity within mental health the APA and National Alliance for Mental Illness recommends the following:

- Include culturally competent services that recognize traditions, histories, values, and beliefs.
- Address minority patients' preferences. Sensitivity and responsiveness to the child or adolescents needs requires ascertaining what matters to the patient and acknowledging the patient's experiences.
- The system can support providers with shared decision-making and improved communication skills and interpersonal relationships through education.
- Ask the patient about their preferences and practice active listening with follow-up questions.
- Recognize the impact of the community on the patient including mental health symptoms.
- Improve evidence-based practices through research.

INTEGRATED CARE IN JUVENILE DETENTION

Unmet physical health needs among youth in the juvenile correctional system are a crucial point of intervention. According to the Survey of Youth in Residential Placement, more than two-thirds of youth identified a health care need, including injury, problems with vision or hearing, dental needs, or "other illness."[43] Pediatricians and other health care providers deliver care to this high-risk population, particularly in the arena of dental care, traumatic injury, tuberculosis, sexually transmitted infections, and pregnancy.[43,44] According to the National Commission on Correctional

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Healthcare's *Standards for Health Services in Juvenile Detention and Confinement Facilities*, youth should be screened on arrival for urgent health care or mental health needs, followed by a comprehensive health and mental health screening. A policy statement by the American Academy of Pediatrics (AAP) for Health Care for Youth in the Juvenile Justice System calls for delivery of the same level and standards of medical and mental health care as nonincarcerated use in their communities.[44] Although some service delivery may be mitigated by length of stay in the facility, at minimum, care should include the identification and treatment of immediate medical and psychiatric needs. Close coordination and collaboration between mental health and medical providers can help ensure all needs are adequately addressed, as well as to ensure continuity of care and prevention of duplicate services. All providers can help youth and families identify a medical home within the community and collaborate with probation officers who often help families navigate medical and mental health care follow-up on reentry into the community.[44]

Working with Families of Justice Involved

Family plays an integral part in the positive and negative outcomes of adjudicated youth in and out of juvenile detention facilities. Positive family involvement provides a supportive and emotionally stable environment in addition to the navigation of the needs of the child in the educational, mental health, and legal systems. Despite challenges associated with family involvement, optimal youth outcomes depend up positive family involvement.

Studies indicate positive family involvement improves treatment compliance, truancy and educational outcome, frequency of suicide attempts, aggression, parenting skills, social development, eating disorders, depression, and anxiety.[45,46] Family involvement typically entails a 3-step process. The first step is to engage families in care. Universal strategies include the creation of an open and welcoming environment. The treatment provider's goal is to improve family input, define what is available to the family, establish protocols for family involvement, and encourage social activities. In the second step, family treatment strategies are more selective. Clinicians must determine specific needs of the family that improve family compliance and provide assistance with resolving family needs. The third step addresses the unique needs of the family and their child. Treatments at this stage are individualized and intensive.[46]

Throughout each step, the clinician must empower the family to speak and be heard, respect the family's perspective, create a collaborative environment, address family needs, address family barriers to care, build off the family's strengths, create opportunities for family involvement, and improve family decision-making.

Immigration and Family Separation

A unique population of youth currently in detention facilities are those who seek asylum or who immigrated to the United States. Asylum seekers and migrants have increased vulnerability for worsened mental health outcomes, thought to be related to premigration experiences of persecution as well as traumas occurring in home countries.[47–49] The postmigration process of seeking asylum may in itself be considered a risk factor, given the trauma associated with interviews or immigration hearings[49] as well as prolonged detention and asylum proceedings.[50]

New US immigration policies have further complicated the process of seeking asylum. In April 2018, under the administration of President Trump, the United States introduced a "zero-tolerance" strategy at the US-Mexico border.[51] Under this policy, all adults entering the United States illegally, even those seeking asylum, were detained and prosecuted. As children cannot be held in federal jails under US law,

they were separated from their families and placed in Department of Health and Human Services detention facilities. Estimates report that 2300 children were removed from their parents in 2018.[51] As of December 2020, 628 children remain separated from their families.[52] Among those youth who were reunified with their caregivers, symptoms of social withdrawal, disorientation, and distress were described; in some cases, children were not able to recognize their parents.

The AAP,[53] the American College of Physicians (ACP), and the APA[54] have released statements opposing the separation of children and families due to the risks of considerable harm.[55,56] Before the institution of the "zero-tolerance" strategy, a 2017 report by the AAP reported basic standards of care for children were not being met in detention centers.[53]

Studies on the effects of detention and separation in children are limited. A 2018 systematic review by von Werthern and colleagues found that all detained children met criteria for at least one psychiatric disorder, with affective disorders being most prevalent, including depression, anxiety, and PTSD. Children and their families also reported difficulties with sleep and appetite.[50] Younger children may display developmental difficulties, including delays or regressive behaviors. Existing literature suggests that children who are detained display higher rates of emotional and interpersonal problems as rated by their mothers[55] when compared with scoring guidelines. Male children had higher rates of abnormal peer problems, and younger children had higher rates of abnormal conduct, hyperactivity, and overall difficulty when compared with older children.[49] The length of separation was not found to be significant, implying that any period of separation may be sufficient to cause harm.[55,56] When comparing detained children with asylum seekers in the community, detained children were found to have higher rates of conduct disorder, emotional problems, and hyperactivity.[57] These difficulties persist despite reunification.[58]

Studies to inform best practices in the care of immigrant youth and families postreunification are sparse and primarily focus on children and adolescents who immigrated separately from their parents. Treatment paradigms are focused on trauma-informed care and encourage collaborative models, with participation from health care providers, educators, and community supports.[59] There is no literature available on the long-term treatment of children who were detained and separated from their parents at the time of writing.

SUMMARY

One of the best clinical experiences a psychiatrist can have is working with extremely high-risk youth to help them find safer and better developmental pathways. Few settings can offer such an opportunity to leverage clinical skills to improve the lives and futures of children and adolescents as are afforded to those professionals lucky enough to work in juvenile justice settings. The work is challenging. The work is not without risk. But the work can be a powerful tool to help our patients and our communities.

CLINICS CARE POINTS

- Incarceration, in and of itself, can exacerbate underlying psychiatric illness and create substantial psychosocial risk factors; it should not be undertaken capriciously but only with specific indications and in accordance with prevailing law.
- Psychiatric illnesses, trauma, psychosocial stressors, and social determinants of health are common in justice involved youth and compassionate, evidence-based management is essential to address clinical needs and risk for recidivism.

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- Juvenile justice systems disproportionately impact BIPOC youth; clinicians should be sensitive to the potential impact of systemic bias and racism in the experiences of their patients.
- Seclusion, solitary confinement, and unnecessary separation from families can be especially traumatic in juvenile justice and immigration settings.

DISCLOSURE

The authors have nothing to disclose.

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