National Juvenile Detention Association | NJDA

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Testimony of Leonard B. Dixon, Director

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Before the United States Senate Committee on Governmental Affairs

"Juvenile Detention Centers: Are They Warehousing Children with Mental Illness?"

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Thank you for the opportunity to testify before you today. I am Leonard B. Dixon, President of the National Juvenile Detention Association and Executive Director of the Wayne County Juvenile Detention Facility in Detroit, Michigan. I wish to thank Chairman Collins and Ranking Member Lieberman and Representative Waxman for inviting me here today to discuss with you my views on the report submitted by the Special Investigations Division of the Minority Staff of the House Government Reform Committee titled, *The Incarceration of Mentally Ill Youth Waiting for Community Mental Health Services in the United States*.

The report served to highlight the seriousness of one of the most difficult issues facing all Juvenile Detention Facilities across the nation, and its impact on the daily operation of these facilities across the country cannot be underestimated. In my testimony, I'd like to outline the scope of the problems facing juvenile detention facilities in detaining and caring for mentally ill youth. The problems range from identifying youth with mental illness, accommodating them in our facilities when required, and ensuring that the youth get timely release into mental health placements.

Currently as the Executive Director of a secure detention facility located in Detroit, Michigan, and also having experience at detention facilities in both urban and rural areas in Florida, I have seen first-hand the hopelessness in the faces of youth who are inappropriately placed in secure detention facilities as a means of controlling their behavior.

The corrections community has long been sympathetic to the needs of juvenile offenders with special needs. In 2001, The National Juvenile Detention Association adopted the following position statement, which I have submitted with my written testimony for the record:

> The National Juvenile Detention Association (NJDA) strongly advocates that juvenile offenders with severe mental health issues, who have been identified by a qualified

> mental health professionals, be placed in the appropriate therapeutic environments instead of juvenile detention facilities. When juvenile detention facilities are forced to house youth with severe mental health issues, NJDA promotes the provisions of adequate services by appropriately trained and licensed specialists.

Despite our efforts to ensure that those in need of mental health services do not end up in our custody, parents are often forced to choose the confinement of their child with mental health issues in a detention center as a two-prong solution to a crisis situation: (1) in detention, the child is protected from harming himself, others or destroying the home and property of others, and (2) the family receives a respite while the acting out child is detained regardless of how long the child remains in secure detention. This is done because other options are not available.

Within my facility, social workers and clinicians plead with parents to allow their child with mental health issues to return home, but they are often unsuccessful in their quest for reunification. More often than not, this occurs because families have exhausted all attempts at mental health placements out of the home and the parents are done dealing with the behavior of their children. It also needs to be stated that regardless of the acuity of the situation, long waits in detention for younger children, girls and those with mental health issues are the rule, not the exception.

From May 1, 2003 to May 31, 2004, the Wayne County Juvenile Detention Facility admitted 4,152 youth between the ages of 10 and 17. Of that number, 2,331 were identified as needing and received mental health services. This figures constitutes 56.15% of our 2003-2004-admission population. These figures are reflective of those found in the national report commissioned by Senator Collins and Representative Waxman.

There are several factors within the field of juvenile justice constitute a reasonable argument for ensuring that the inappropriate placement of youth with mental health issues in detention facilities ends. The most compelling argument is that detention for youth is generally short-term and does not include nor guarantee the provision of any type of formalized treatment to address identified disabilities, including mental illnesses. Youth with mental health issues require support and management services that often exceed the level of training provided to the detention staff. These same youth require services that are often not included in operation budgets for detention facilities such as psychological examinations, mental health assessments, specialized units and counseling by licensed clinicians. Despite the limited availability of Medicaid funding for needed services and mental health parity with medical services through insurance providers, demand for resources far exceeds supply placing undue strain on our nation's juvenile detention centers. This prevents juveniles in detention settings from receiving the appropriate services that are specific to each child's needs while detained, with dignity and respect.

A second reason for ensuring that youth with mental illnesses are not detained in juvenile detention facilities is that they are more difficult to manage, more explosive, more easily agitated, require more intensive supervision and create more strain on direct care staff than other youth within a juvenile detention facility. Management of youth with mental health issues results in a higher number of injuries to both staff and youth, the destruction of property with resulting building repairs and an increase in the off-site hospital visits for self-mutilating behaviors, psychotic episodes, suicide attempts, injuries from physical management and fights with other residents. Most juvenile detention facilities do not have the luxury of separating youth with mental health issues from the general population. This creates an atmosphere of conflict and unrest for everyone and the potential for crisis can be very high.

The need for collaboration with mental health agencies in the community is often very difficult, but it is extremely important to the term care of these youth. The most critical reason for the gap in networking on behalf of youth is the lack of coordinated communications between mental health and juvenile justice systems. A youth receiving mental health services can be in custody with detention staff having no knowledge of the youth's involvement in the mental health system. Unless the youth self-reports, the parent reports or the youth has previously been in the juvenile justice system, the detention staff will not be made aware of his or her existing or pre-existing involvement in the mental health system. To add to this problem, oftentimes the records of a youth who has received mental health services in the community, when requested, are not received by the detention facility in a timely manner.

Even when the youth has been identified as a recipient of mental health services, community mental health caseworkers are often unavailable to attend delinquency court hearings with parents on the youth's behalf to substantiate the need for the continuation of mental health services. Lacking the support of caseworkers, the youth often ends up in being sent to secure detention rather than receiving community mental health treatment.

Unfortunately, the majority of youth with mental health needs are housed in secure detention facilities far longer than their counterparts with similar charges and offenses. This is often caused by the inability of community-based mental health providers to provide services to those the court has ordered to be placed in mental health facilities and hospitals. The waiting lists for these type of placements are excessive and the waiting can result in the youth deteriorating, sometimes to the extent that the original placement may no longer be specific enough or applicable to the youth's needs.

One of the most challenging segments of this population, yet one that is not often specifically addressed, is female youth with mental health issues. There is a serious need for specialized services to address the fastest growing population in the field of juvenile justice – girls and youth with mental health issues. Most females entering the juvenile justice system have been physically and sexually abused and require protection from perpetrators, often in their own families. Specialized and gender-specific services for girls are limited and male programs cannot be painted pink to give the impression that they were designed for a female population.

I would like to share with the Committee three stories of youth with mental health issues placed in my facility and the extent to which services were provided and were secured to address the needs of the youth.

The first case involved a sixteen-year old male youth admitted to the detention facility on an assault charge for allegedly stabbing a classmate in the neck with a pencil while experiencing auditory hallucinations. This case illustrates the point that children and adolescents may commit crimes that are the result of very serious mental illness.

Upon admission, the youth was clearly psychotic and very depressed. He was transferred to a psychiatric hospital where he remained for two weeks. When he returned to detention, he continued to speak about having command hallucinations and paranoid thinking. After staying in detention for several months he was released into the custody of his father who secured a bed for him in a long-term treatment hospital in a neighboring state. While in treatment, his progress was slow but steady. The court ordered a competency evaluation; however, his treating psychiatrists contacted the court's clinic and informed them that the youth was in no condition to travel back to the state for this evaluation.

The judge was not satisfied with this evaluation of the youth and issued a Writ for the youth's return to secure custody in detention. The youth was first housed in a detention center in the same state as the hospital before being transported back to our facility where he remained for several months. Mental health staff at the detention facility requested that his stay be as brief as possible, but we had no impact on his length of stay. The court finally declared the youth incompetent to stand trial and, luckily, his father was able to return him to the psychiatric hospital for treatment.

According to our Mental Health Director, this youth was diagnosed with Schizoaffective Disorder and had a parent who had been diagnosed with Schizophrenic Disorder. A youth with this type of disorder needs intensive mental health treatment, not incarceration. If they are awaiting adjudication, they must be cared for in a forensic setting with extensive mental health services. It was very fortunate that this youth was in a detention facility where a wide array of mental health services, including a mental health unit, to support the youth and keep him from deteriorating during the time it took his legal case to be resolved in court were available.

The second case involves an eleven-year old female youth admitted to the detention facility on a charge of domestic assault because she and her mother were fighting with each other. According to our Mental Health Director, this case is an example of very young children entering the juvenile justice system because families are not given adequate support in the mental health system. This youth has a long history of emotional problems that began in early elementary school, and several members of her family have been diagnosed with Bipolar Disorder. Her mother had suffered with depression in the past.

At age eight, she was hospitalized in a psychiatric facility for the first time because of aggressive behavior toward her mother. Before entering the juvenile justice system, she had two more inpatient psychiatric hospitalizations. She was involved in therapy and was placed on several different types of psychotropic medication; still she began to develop anxiety about school and then flatly refused to attend. The attendance officer pressed her mother to have her regularly attend 5th grade classes at her elementary school, yet the youth refused to attend school.

Because of her mental health history and anxiety upon admission, the youth was admitted to the Mental Health Unit of the juvenile detention facility. At first, she was tearful, frightened and somewhat oppositional. As time went on, she became more comfortable and compliant. It was very apparent to the mental health team that her difficulties were related to her relationship with her mother and would be best addressed in family therapy.

Although the referee had set a low bond for her release, her mother refused to pay it and take her daughter home to "teach the child a lesson." The youth remained in detention for six weeks before a review hearing was scheduled and her mother allowed her to return home. The youth was returned to our facility in less than five weeks because her mother told the court that her daughter was refusing to follow directions. She remained in detention for an additional 3 months as she awaited placement with mental health services.

In this case, the mother needed to have the child out of her house in order to regain control. Yet, the mental health system was unable or unwilling to assist her. This family should have been engaged in outpatient therapy and the detention system should not have been used to separate the child from her mother.

The third case is a clear example of a child who began in the foster care system and was placed in a detention center when his behavior began difficult to manage. It involves a fifteen-year old male youth who entered foster care when he was nine years old because of abuse and neglect. The youth had never returned home since that time. He had been in and out of a detention facility at least eight times, beginning at age ten, because of aggressive, explosive behavior that led to charges of malicious property damage or felonious assault against him. He has been hospitalized two times at a long-term psychiatric hospital, has been in many residential facilities contracted with the foster care system and has been tried on numerous psychotropic medications. During his journey, he learned that he could exit a community mental health placement by becoming aggressive because this would return him promptly to a detention facility – a place that he refers to as "home."

During his last stay at our facility at Christmas, he was very depressed and began to engage in self-mutilating behaviors. As a result he was placed on constant watch, supervised by one staff member. Yet, somehow he managed to find tiny slivers of broken glass in a room where another youth with mental health illness had broken a glass earlier in the day. He told the detention staff that he had swallowed a piece of glass and was sent to the emergency room. From there he was transferred to a psychiatric hospital for treatment of his depression. After a three-day stay, he pulled the fire alarm that opened the locked doors of the hospital and he escaped.

He had planned all along to go back to his old neighborhood to look for his family. He managed to elude the authorities for several months and visited with relatives before being apprehended and returning to our facility. Upon his return, he was disillusioned about his family and sadly reported that he felt unconnected to them.

He has been in detention for more than three months now and is still waiting to be sent to a placement suitable to his plethora of needs in addition to his extensive history of aggressive behaviors. To date, he continues to explode intermittently with staff and peers and has recently begun to refuse his psychotropic medication.

The Foster Care System has not been able to access placements managed by the mental health system. This youth has exhausted a long list of foster care placements that have not had the fortitude or clinical skill to provide him with consistency and stability. Consequently, this youth has learned how to get back to the detention system where he regards the staff and peers as family and has developed some very anti-social behaviors in the process.

In closing, I offer the following recommendations to the committee:

1. All youth should be assessed for mental health issues by a qualified, trained, licensed mental health professional prior to detainment in the juvenile justice system.

2. Detention facilities for youth must have ready access to mental health service providers to ensure the needs of the over 40 to 50 % of their population who require mental health services are able to access them.

3. State mental health systems must develop a seamless system of care to track youth with mental health issues and to ensure that youth are considered for least restrictive placements. In particular, placements for young children must ensure that youth enter the system at the needed level of care.

4. Child and adolescent psychiatric hospitalization must be made available and accessible to families at the time of the crisis helping to ensure that detention facilities are not used as treatment facilities.

5. Community mental health agencies and service providers should be local and accessible to families, even in rural communities. Respite services; transportation and after-hour appointments must be available upon request of the family;

6. Residential facilities should provide a wide array of specialized services for complex populations including abuse/neglect, aggressive/explosive, and sexual victims/perpetrator.

7. Gender-specific services for girls must be developed to address the multi-layered problems underlying their delinquent behaviors.

8. Systems, to include foster care, juvenile justice, child welfare, mental health and education, must unite to provide a system of care to address every aspect of the youths' development.

9. Medicaid and other funding sources identified for youth services must follow the youth and not become available only when the youth enters the system at a designated level of care. Special emphasis must be placed on mental health parity with medical services for our most valuable resource – our youth.

Currently before Congress are two bipartisan proposals that merit consideration and swift approval which would help to fill the gap between treatment and detention. The Keeping Families Together Act, introduced by Senator Collins and others, would help reduce the number of children with mental or emotional disorders in juvenile detention centers by supporting states' efforts to develop coordinated systems of care. The Mentally Ill Offender Treatment and Crime Reduction Act would help to promote collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems in diverting individuals with mental illness from the criminal and juvenile justice systems and would promote treatment within those systems.

I thank you for your time and hope that this issue remains at the forefront of your consideration and that positive change is forthcoming in the very near future.