OYCR | Office of Youth and Community Restoration

Practice Guidelines for Treating Behavioral Health Disorders in SYTFs and Other Facilities

EXECUTIVE SUMMARY

Background: Youth in the juvenile legal system have disproportionately high rates of behavioral health disorders[1] and often require specialized treatment to support their rehabilitation and recovery. Secure youth treatment facilities (SYTFs) necessitate specific adaptations to mental health and substance use services to ensure high quality of care while maintaining facility safety. In turn, professional organizations providing behavioral health services in correctional settings have developed tailored guidelines to inform practice. This brief focuses on guidelines for the provision of clinical behavioral health services, although many of the tools reviewed are also used for other purposes, such as by probation staff to assist with intake. This brief summarizes the relevant practice recommendations and minimum standards of care from these organizations and provides links to resources for counties desiring more detailed and specific information on various aspects of treatment in SYTFs and other placements along the continuum of care.

Clarification of Minimum Standards of Care: This brief summarizes the "minimum" standards of behavioral health care recommended by relevant organizations that should be implemented within the juvenile legal system. These kinds of "minimum" standards of care and others across professions are considered typical and have been created solely to ensure that professional obligations to patients (in this case, young people) are being met (Vanderpool, 2021). However, best practices can also promote "optimal" standards of care that go above and beyond the professional obligations listed in minimum standards of care. While this brief lists currently accepted "minimum" standards of care in behavioral health services, we hope that "optimal" standards of care are championed in behavioral health services and other areas in California's jurisdictions, as optimal care can promote sustained healing and rehabilitation of youth in the juvenile legal system.

[1] "Disorder" is the current medically accepted term to describe the wide range of conditions affecting behavioral health that are described in this brief. Our intention is not to offend or pathologize youth and their families; however, to maintain consistency with current medical practices, this term is used throughout this brief.

Search Strategy: We searched the keywords “juvenile substance use treatment”, “juvenile mental health treatment”, “juvenile incarceration treatment guidelines”, “behavioral health juvenile facility”, “juvenile facility treatment guidelines”, and “juvenile best practice” in the following databases and resources: Google Scholar; ProQuest Social Service Abstracts; National Criminal Justice Reference Service. We also searched these terms in the resource libraries of the Office of Juvenile Justice and Delinquency Prevention (OJJDP), the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), the American Society of Addiction Medicine (ASAM), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Articles that focused on substance use or mental health practice guidelines for youth in carceral facilities were prioritized, but for certain practice areas and clinical situations where literature meeting these criteria were not available, we also included substance use and mental health practice guidelines developed for the general population of adolescents, or for adult correctional settings.

Results and Conclusion: The National Commission on Correctional Health Care (NCCHC) has developed a set of minimum standards for health care (including behavioral health treatment) in youth carceral facilities (National Commission on Correctional Healthcare, 2022). *We strongly recommend that all SYTFs and other facilities in the continuum uphold these standards of care,* and that counties consider requiring NCCHC accreditation for the principal provider of behavioral health treatment at the facility.

In addition to the NCCHC minimum standards, other professional organizations have developed relevant guidelines that may be useful for behavioral health practice in SYTFs, including the American Academy of Pediatrics (Committee on Adolescence et al., 2011), the Bureau of Justice Assistance (K. Price, 2020), the American Academy of Child and Adolescent Psychiatry (Penn & Thomas, 2005), the Substance Abuse and Mental Health Services Administration (Substance Abuse and Mental Health Services Administration, 2019), and the American Society of Addiction Medicine (Mee-Lee et al., 2013). *We encourage counties to utilize these additional resources, as well as the cited peer-review articles to inform their practice.*

This report summarizes the guidelines and standards for behavioral health practice in SYTFs and other facilities in the continuum established across these various resources. Primary domains of best practice include screening and assessment, treatment planning, care continuity, medication management, evidence-based tools, staff training and credentialing, cultural and gender sensitive treatment, medication-assisted treatment, family engagement, developmental appropriateness, and safety protocols. This report also describes guidelines for specific clinical situations (e.g., co-occurring disorders, crisis intervention, withdrawal, overdose), and additional recommendations to further enhance the quality of care (e.g., facility environment, behavioral health housing, peer supports, holistic supports, behavior management systems, health insurance, case management, acknowledgement of racism in juvenile legal system, leadership, and data collection).

Minimum Standards for Mental Health and Substance Use Treatment

Expert professional organizations concur that youth who are sentenced to youth carceral facilities should receive treatment that meets the minimum standards of care, as outlined in professional practice guides (Committee on Adolescence et al., 2011; Mee-Lee et al., 2013; Penn & Thomas, 2005; K. Price, 2020). These minimum standards reflect the essential domains of practice that should be available in all facilities for youth where treatment is clinically indicated. While these standards are summarized below, to ensure effective implementation, we recommend that county providers uphold the NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities and the NCCHC position statements on behavioral health care in correctional facilities (such as for the treatment of opioid use disorder, suicide prevention, and trauma-responsive care) and consider NCCHC accreditation. Any evidence-based program adopted to clinical care should follow fidelity principles and be monitored for adherence to the specific intervention.

- **Screening and Assessment:** All youth entering facilities should receive prompt screening for behavioral health disorders including mental health concerns and substance use. If screening indicates an emergency behavioral health concern, such as imminent risk of suicide, youth should be immediately referred to a behavioral health clinician and/or the emergency room as appropriate. All youth with positive screens should receive comprehensive clinical behavioral health assessment.[2] Screening and assessment tools should be evidence-based, incorporate information from a range of sources (e.g., diagnostic tools, interviews with youth and families, collateral contacts, etc.), and be administered promptly within the appropriate timeframe as outlined in the practice guidelines (for specific timelines, see: Committee on Adolescence et al., 2011). Youth should be continually re-assessed during confinement and prior to re-entry as symptoms may evolve and/or improve (Committee on Adolescence et al., 2011; Grisso & Underwood, 2004; Underwood et al., 2014). For an extensive review and comparison of specific assessment tools, it is recommended that counties consult the OJJDP Resource Guide "Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile System" (Grisso & Underwood, 2004) and the forthcoming OYCR brief on assessment.
- **Clinical Treatment Planning:** All youth with indicated behavioral health disorders should have a comprehensive, individualized treatment plan developed to address their unique needs and concerns identified during the assessment process. Treatment plans should also incorporate considerations related to a young person's legal case, their length of stay in the facility, and the resources available in that setting to ensure that services are not abruptly discontinued or unavailable. The need for ongoing treatment should not be used as a reason for initiating or prolonging a young person's stay in an SYTF or other residential placement facility. Therefore, if youth require ongoing services

[2] For more specific details and information for each area, please refer to the recommended resources cited in that section, and the forthcoming OYCR brief on comprehensive assessment.

toward the end of their placement in a facility, these services should be provided in the community or through a lower-level program. Additionally, treatment plans should be culturally sensitive and be developed in partnership with youth, their families, relevant members of their social support system, and applicable oversight agencies; and revised throughout the young person's time in custody (Committee on Adolescence et al., 2011). Treatment plans should be incorporated into a young person's Individualized Rehabilitation Plan (IRP) so that providers are mutually aware of goals for the youth.

- **Care Continuity:** Facilities should prioritize continuity of care throughout young people's treatment in custody and continuing into the re-entry process. In facilities, care continuity is aided by collaboration between providers and intentional integration of the various aspects of assessment, planning, and service delivery that a young person is receiving (e.g., coordinated substance abuse and mental health treatment). Continuity of clinical services is also imperative to re-integration, and intentional planning for the transition out of custody must start from the time youth arrive to the facility to ensure accessibility to services and interventions after their release. Facilities should collaborate with community-based providers to ensure youth are linked to appropriate services in the community. Relevant clinical information and useful records about behavioral health diagnoses, care rendered during confinement, and recommended follow-up should be shared with youth and families. To prevent service interruptions and facilitate smooth transition of care during youths' transitions in the continuum, this information should also be shared with ongoing and subsequent providers (Committee on Adolescence et al., 2011; Underwood et al., 2014; Whitley & Rozel, 2016). Additionally, community-based family therapy models may also support re-entry. Some examples of programs that have been widely used in youth carceral settings include Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST).
- **Medication Management:** Facilities must ensure that medication is prescribed and fulfilled appropriately. Medications for treating behavioral health disorders should be prescribed when clinically indicated and as part of a comprehensive treatment plan coupled with psychosocial therapy and medical psychoeducation. Youth who are already taking medication when entering facilities should continue their existing medication regimens until comprehensive assessment by a qualified provider has been completed, and youth transitioning out of facilities should be proactively linked to community-based providers to ensure continuity in access to medication (Thomas & Penn, 2002; Whitley & Rozel, 2016)
- **Training and Credentialing:** Clinical treatment teams who deliver behavioral health services (such as social workers, psychologists, and psychiatrists) in SYTFs should include staff with the appropriate credentials for delivering specific interventions and assessments. Additionally, clinical staff should receive training specific to the unique challenges of working in a youth carceral facility, including confidentiality issues, differences in symptom manifestation in correctional settings, and facility culture and rules. Facility staff should also receive basic training in recognizing mental health crises,

intoxication, or withdrawal, and in protocols for swiftly referring youth to clinical staff when necessary. Both clinical and facility staff should receive ongoing training to learn evolving standards in the field (Nissen, 2006; Thomas & Penn, 2002).

- **Evidence-Based Models and Tools:** To treat behavioral health concerns, practitioners should utilize evidence-based practices and tools that are transferable to correctional settings and can be delivered with fidelity in the context of the facility's capacity (K. Price, 2020; Underwood et al., 2014). Various resources such as the Blueprints Registry for Healthy Youth Development, the Office of Juvenile Justice and Delinquency Prevention Model Program Guide, and the guide "Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs" (Virginia Commission on Youth, 2017) offer detailed reviews of model programs and practices. One example of a relevant model is: "Multi-Systemic Therapy- Family Integrated Transitions" (Trupin et al., 2011), which specifically supports re-entry for young people with mental health and substance use needs. Other promising evidence-based models that provide intensive mental health and/or substance use treatment to youth in residential care include the "Residential Student Assistance Program", the "Adolescent Community Reinforcement Approach", or the Mendota Juvenile Treatment Center (it should be noted that there are some differences in the facility settings and populations included these models that may not be generalizable to SYTFs and other placements and their populations). Additionally, treatment models developed and tested for the general youth population (e.g., trauma-focused treatment, motivational interviewing, cognitive-behavioral therapy) or family-based models developed for community-based youth programs may also be promising, but components may need to be adapted to different settings. Counties should consult the guide "Adapting Evidence-Based Practices for Under-Resourced Populations" (Substance Abuse and Mental Health Services Administration, 2022) for guidance on adapting such programs to their respective facilities and partnering agencies.

- **Cultural and Gender Sensitive Treatment:** Clinicians should incorporate understanding of the unique experiences, perspectives, and needs of youth from different racial and cultural backgrounds, and from female-identified and LGBTQ+ youth. When applicable, behavioral health care delivery should also align with professional treatment standards for transgender health care, such as those outlined by the World Professional Association for Transgender Health (WPATH) and the NCCHC. Moreover, standardized assessments are often based on European-American standards and values, and clinicians' biases may be reflected in their evaluations of young people's symptoms and progress. Clinicians should aim to honor and respect the diverse beliefs, styles, and behaviors of young people (K. Price, 2020; Terry et al., 2000).

- **Medication-Assisted Treatment (MAT)**: Medications can be a valuable asset to assist with withdrawal and maintenance in addiction treatment. MAT is widely researched and supported for adults, including in correctional settings, and there is some emerging research demonstrating its efficacy with younger youth. The American Academy of

Pediatrics has endorsed the use of MAT as a component of treatment for minors with substance use disorders. Extensive resources addressing aspects such as licensing, funding, guidelines for dosing and tapering, and concerns including misuse have been developed for implementing MAT in correctional settings (Klein, 2018; K. Price, 2020; US Department of Health and Human Services, 2019).

- **Family Engagement:** Families and caregivers of youth should be involved in determining the youth's care plan and engagement throughout the clinical process, including during assessment, treatment planning, and transition planning. Clinical and facility staff should conduct appropriate outreach with family members and connect them to resources so that they can best support their child. Family-based treatment models are especially promising for youth with mental health and substance use disorders, especially in the facility context (Chapman et al., 2006; Fletcher & Chandler, 2014; Nissen, 2006; Whitley & Rozel, 2016).
- **Developmental Appropriateness:** Clinicians should incorporate understanding of youth development into assessment and treatment. This includes recognizing how changes to the brain during this period of development influence cognition and behavior (e.g., impulsivity, emotionality, or succumbing to peer pressure to experiment with substances). Treatment should also incorporate developmental considerations of key milestones during adolescence and early adulthood. This can include promoting the youth's autonomy by emphasizing them as partners in treatment planning or encouraging them in developing a drug and crime-free identity (Chapman et al., 2006; Nissen, 2006).
- **Seclusion and Restraint:** Seclusion and restraints are detrimental and traumatizing for youth and should never be used as a form of discipline. The American Academy of Child and Adolescent Psychiatry and the NCCHC released policy statements describing that restrictive measures should only be considered as a last resort when a physician has assessed that the severity of a young person's psychiatric symptoms is creating imminent danger to that youth and others, and that such measures will prevent further harm and alleviate psychiatric symptoms (American Academy of Child and Adolescent Psychiatry, 2012; National Commission on Correctional Health Care, 2021a). In this case, such measures should be used for the shortest time possible, with the minimum degree of restrictiveness and close supervision by a qualified practitioner (Whitley & Rozel, 2016).

Guidelines for Specific Clinical Situations

In addition to the minimum standards to be used for informing treatment, there are also guidelines developed for specific clinical situations and concerns. We recommend that counties consider preparing to be equipped to respond to these situations in facilities.

- **Co-Occurring Disorders:** Many youth in the juvenile legal system experience multiple mental health and/or substance use disorders, which should be addressed together through integrated assessment and treatment. Recommendations include collaboration between staff in mental health and substance use divisions, targeted assessment of the coinciding effects of symptoms from multiple disorders, and the development of plans that progress through targeted stages and reflect integrated treatment of multiple disorders (Mee-Lee et al., 2013; K. Price, 2020; Substance Abuse and Mental Health Services Administration, 2019)
- **Crisis Intervention:** Crisis intervention should focus on relieving symptoms of distress and de-escalating situations that are posing a risk to youth or others. Youth demonstrating self-harm, suicidal ideation, or homicidal ideation may be in psychiatric crisis, and should immediately be referred to a qualified clinician to conduct further assessment. Facilities should have a tiered process in place to respond to youth with clinically indicated symptoms of psychiatric crisis, including the use of established de-escalation techniques (O. Price & Baker, 2012) such as the Positive Behavioral Interventions and Supports (PBIS) approach (Kumm et al., 2020), appropriate monitoring and supervision, and a process to slowly reinstate independence and introduce youth back into general activities. The use of seclusion or restraints during crisis should adhere to the guidelines specified above, including only being used as a last resort and under the direction of a physician to prevent imminent harm to the young person or others. Suicide attempts or self-harm will nearly always require emergency medical or psychiatric care (Boesky, 2014; National Commission on Correctional Health Care, 2019c; Whitley & Rozel, 2016).
- **Withdrawal:** Current guidelines for withdrawal in custody are largely developed for adults. However, they may offer the best standards at present for youth. Staff should be trained in recognizing symptoms and have a procedure in place to refer youth to a qualified clinician for further assessment if symptoms are indicated. Youth going through withdrawal should be monitored in designated intervals by qualified medical staff and placed in an appropriate level of care depending on symptom severity, substance, and other factors. Counties should assess whether they have capacity to manage withdrawal in facilities, or otherwise connect to appropriate community-based providers to do so. Medication-assisted treatment may also be a valuable resource for youth going through withdrawal (Bureau of Justice Assistance, 2023).
- **Overdose**: There appear to be limited resources specific to addressing overdoses in youth carceral facilities. However, guidelines for adults and community-based settings may provide the best resource at this time. The NCCHC recommends that jurisdictions train facility staff as well as individuals who are incarcerated to recognize signs of overdose, implement procedures to prevent overdoses, and carry overdose reversal drugs such as naloxone for prompt administration when needed (National Commission on Correctional Healthcare, 2020; US Department of Health and Human Services, 2019).

Additional Practice Guidelines to Enhance the Quality of Care

In addition to minimum standards, there are numerous evidence-based practices and approaches that can enhance the quality of care and recovery of youth with behavioral health disorders. Counties with the capacity to do so should consider incorporating these principles.

- **Addressing racist systems, institutions, and structures of the juvenile legal system:** Recognizing the inherent racism of the juvenile legal system was expressed as essential by the youth who were consulted in the writing of this brief. As detailed in the National Commission on Correctional Health Care's 2023 Position Statement on Racism, racism is inherent to both the juvenile and criminal legal systems. Racism has shaped the policies and practices that have led to the overrepresentation of young people of color in the system and subsequent mistreatment and oppression during incarceration. Additionally, racism has also influenced the delivery of treatments to youth who are incarcerated. Recognition of the systemic, institutional, and structural racism that has shaped the juvenile legal system can lead to improved care. Counties can acknowledge the racism that pervades their systems to mitigate its impact on youth and families. In the context of behavioral health, practitioners can address the traumatic effects of racism and be mindful of their own implicit biases when treating youth. Additionally, as suggested by the NCCHC, staff training and other interventions that address the racial trauma affecting youth and families are recommended. To our knowledge, behavioral health interventions that specifically address racial trauma within youth carceral facilities have not yet been defined. However, counties and care providers are encouraged to be creative in using resources such as credible messengers, who can help address the effects of racial trauma during treatment planning and delivery.
- **Trauma-Informed and Developmentally Sensitive Environment:** To ensure behavioral health interventions conducted in a facility are conducive to healing and recovery, the facility's conditions, policies, and practices must promote safety and be trauma-sensitive and developmentally appropriate (Substance Abuse and Mental Health Services Administration, 2014). Key aspects of a safe, trauma-sensitive, and developmentally appropriate facility environment include: promoting a non-punitive facility culture; demonstrating respect to youth and families' strengths, needs, and rights; ensuring physical and psychological safety; meeting basic needs related to hygiene, sleep, social interaction, recreation, and nutrition, among others; and ensuring access to rehabilitative health care and educational resources as well as other essential supports to promote healthy development and well-being (National Commission on Correctional Health Care, 2019a, 2021b, 2022, 2023).
- **Behavioral Health Housing Units**: For youth with serious and persistent behavioral health disorders, it may be appropriate for them to reside in housing units that are designed to function as clinical treatment settings to ensure enhanced access to care for the young person, as well as the safety of all youth and staff. These settings are staffed and operated similarly to adolescent inpatient mental health facilities, increasing their

therapeutic capacity (Underwood et al., 2014). Regardless of whether youth are in specialized housing, youth with serious behavioral health disorders may require greater supervision, including one-to-one staffing.

- **Peer Support:** There is extensive research supporting the efficacy of peer service models, where trained peers who share the lived experience of addiction and/or mental illness assist others in their recovery process, within the custodial setting and during the re-entry process. While much of the research on this model has been conducted with adults, there is also emerging support for peer models with youth who have behavioral health disorders (McCrary et al., 2022; K. Price, 2020).
- **Holistic Supports**: The benefits of formal clinical interventions may be greatly enhanced by holistic supports and by engaging supportive staff and other individuals with whom youth have trusting and close relationships. Collaboration with supportive individuals including credible messengers, advocates, or mentors during assessment, treatment planning, and service delivery can increase engagement and further strengthen healing and recovery. Other holistic approaches such as mindfulness, yoga, and relaxation techniques can promote further healing and reinforce progress in clinical settings (Murray et al., 2018). Holistic opportunities to engage in prosocial activities and events as well as leadership development opportunities and activities, such as involvement in youth groups, can also enhance therapeutic interventions. Culturally responsive supports such as healing circles should also be implemented whenever possible.
- **Behavior Management Systems**: Behavior management systems using graduated rewards and sanctions are shown to be effective in producing and sustaining long term behavior change for youth struggling with addiction by reinforcing progress. Sanctions should be clear, consistent, and non-punitive. Specific models such as contingency management and behavior contracts are especially promising for counties to consider (Fletcher & Chandler, 2014; K. Price, 2020)
- **Health Insurance**: Incarceration may disrupt healthcare coverage, creating delays with re-enrollment upon release and interrupting care in the community. Jurisdictions should work with youth, families, and insurance providers to maintain healthcare coverage, or prepare to reinstate it prior to release in order to ensure youth can access services to continue treatment in the community (Anderson et al., 2019; National Commission on Correctional Health Care, 2019b; K. Price, 2020).

Case Management: Case managers serve as important advocates for youth and families. Additionally, case management services can assist youth and their families by reinforcing clinical skills and engagement, providing support with navigating complex systems, and connecting them to resources in the community (Chapman et al., 2006; Desai et al., 2006; Terry et al., 2000). In 2024, the CALAIM Medicaid Redesign goes into effect, wherein enhanced care managers can be funded through Medicaid to work with youth in facilities 90 days prior to their release to prepare for re-entry (California Department of Healthcare Services, 2023). Counties and relevant agencies should make use of this expansion of Medicaid to promote a warm

handoff and smooth transition of services and resources for youth upon their reentry into their communities. Case management models used in the state including Integrated Case Management (ICM), Intensive Care Coordination (ICC), and High-Fidelity Wraparound can also be considered for usage by case managers and relevant agencies to promote enhanced case management.

- **Leadership:** Psychiatrists, medical doctors, and clinical supervisors should hold leadership roles directing clinical care services to help ensure that budget and policy decisions reflect therapeutic treatment priorities (Chapman et al., 2006; Terry et al., 2000).
- **Data collection:** Facilities should conduct ongoing data collection and evaluation to assess performance and adherence to standards of care and to improve service quality and accessibility (Nissen, 2006; K. Price, 2020).

Recommended Resources

Guidelines

- National Commission on Correctional Health Care (NCCHC) minimum standards for health care in juvenile facilities
- American Academy of Pediatrics Policy statement on Health care for youth in the juvenile justice system
- American Academy of Child and Adolescent Psychiatry practice parameter for psychiatrists working in juvenile justice settings
- American Society for Addiction Medicine Criteria
- Substance Abuse and Mental Health Services Administration guide to Screening and Assessment of Co-Occurring Disorders in the Justice System
- NCCHC Position Statement on Addressing Systemic, Structural, and Institutional Racism in the Juvenile Legal System
- NCCHC Position Statement on Opioid Use Disorder Treatment in Correctional Settings
- NCCHC Position Statement on Suicide Prevention and Management in Juvenile Correctional Settings
- NCCHC Position Statement on Trauma Responsive Care for Youths in Correctional Facilities
- NCCHC Position Statement on Transgender and Gender Diverse Health Care in Correctional Settings

- Office of Juvenile Justice and Delinquency Prevention (OJJDP) Guide for Screening and Assessing Mental Health and Substance Use Disorder Among Youth in the Juvenile Justice System
- World Professional Association for Transgender Health Standards of Care

Resources on Addressing and Combatting Racism in Juvenile Legal System

- Academic Pediatric Association's Anti-Racism and Equity Toolkit
- American Academy of Pediatrics' book: *Untangling the Thread of Racism: A Primer for Pediatric Health Professionals*

Resources and Examples of Evidence-Based Models and Practices

- Multi-Systemic Therapy-Family Integrated Transitions (MST-FIT)
- Multi-Systemic Therapy (MST)
- Residential Student Assistance Program (RSAP)
- Adolescent Community Reinforcement Approach
- Mendota Juvenile Treatment Center
- Functional Family Therapy
- Trauma-focused Treatment
- Cognitive-Behavioral Therapy
- Family-Based Models
- SAMHSA Guide for Adapting Evidence-Based Practices for Under-Resourced Populations
- OJJDP Model Programs Guide
- Blueprints for Healthy Youth Development
- Virginia Commission on Youth Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs
- Positive Behavioral Interventions and Supports

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