OFFICE OF THE CHILD ADVOCATE
REPORT

JUVENILE DETENTION CENTER INVESTIGATION
An Examination of Conditions of Care for Youth with Mental Health Needs

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November 22, 2004

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In New Jersey, county juvenile detention facilities are often used to confine youth with serious mental health needs. These youth are frequently held in detention centers due to the paucity of less restrictive placement options that would allow them to remain with their families or in their communities, where appropriate, and have access to care to address their identified needs. Detention centers are generally not equipped to identify youth with mental illness, to assess their condition or to provide them with necessary services to assure their stability and support their mental health while detained.

Currently, there are few specific statewide standards to meaningfully address the mental health needs of detained youth; service provision is largely subject to the discretion of county administrators, the individual philosophy of detention directors, and resources available in that particular county. While we can readily accept, and expect, that the physical health of detained youth should be adequately addressed in a timely manner, many youth languish and decompensate in juvenile detention facilities across the State as their mental health needs go unmet while awaiting an appropriate placement. The Office of the Child Advocate (hereinafter "OCA") embarked upon this investigation to determine the extent of this problem and to make recommendations for meaningful reform.

In 2003, the OCA initiated a systematic assessment of New Jersey's 17 county juvenile detention centers and the needs of detained youth with significant mental and behavioral health needs. In an effort to acquire as much information as possible regarding the mental and behavioral health needs of detained youth and best understand the conditions these youth confront in county detention centers, the OCA conducted announced and unannounced site visits to those centers throughout the State. The site visits included inspections of the physical plant, an inventory of the social services provided (with particular attention paid to the methods of mental health screening, types of assessments, and mental health services provided), individual interviews with facility administrators and informal, private discussions with detained youth. In addition, we asked each detention center administrator to complete a comprehensive survey about the facility's population and staff and to provide the OCA with certain facility records and reports describing conditions of confinement for youth with serious mental health needs.

This final report memorializes the OCA's findings and recommendations regarding the confinement of youth with mental health disorders in New Jersey's 17 county juvenile detention centers and the unmet needs of those youth. This report consists of four sections:

(1) Introduction, which summarizes and describes the initiation, scope and framework of the investigation;
(2) Investigation Findings;
(3) Encouraging Developments, which discusses efforts currently underway that may impact detained youth with mental health needs; and
(4) Recommendations, which include a call for immediate corrective action from the New Jersey Juvenile Justice Commission (hereinafter "JJC"), the New

Jersey Department of Human Services (hereinafter "DHS") and counties operating juvenile detention centers.

I. INTRODUCTION

A. Overview of the Juvenile Justice System

A youth generally enters the juvenile justice system when charged with some act of delinquency[1] in a delinquency petition or complaint filing in the Chancery Division, Family Part.[2] Once this petition is made, an initial detention hearing must occur the morning following the youth's placement in detention. At that initial hearing, a determination must be made about where that youth should live, pending the family court's determination of the petition.[3] If the youth is not represented by counsel at that initial hearing, a second detention hearing must be held within two court days.[4] The judge may decide to send the youth home with his or her family, or with an intensive supervision or electronic monitoring program; or the judge may order the youth to be held in a DHS shelter or group home, or the judge may remand the youth to one of the county detention centers.[5]

In general, county detention centers should be placements of last resort for youth, especially youth with serious mental health disorders. While beyond the scope of this investigation, we noted that many youth were detained in apparent violation of applicable State law. The Code of Juvenile Justice at *N.J.S.A.* 2A:4A-34(c)(1)-(2) permits the use of juvenile detention under two limited circumstances. The first is where detention is determined necessary to ensure appearance in court. This determination must be based upon a recent record of failure to appear in court or failure of the youth to remain in a placement made by the court or court intake services. The second is when the child presents a danger to people or property in the community and is charged with an offense that would be a crime if committed by an adult. In addition to these clear statutory limitations, certain categories of youth are to be excluded from detention centers altogether. According to *N.J.S.A.* 2A:4A-34(c)(3), a child charged with an offense that would be a disorderly persons offense if committed by an adult must be held in a shelter or other non-secure placement, if detention is determined to be necessary.

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* The OCA expresses special gratitude to Bruce D. Stout, Ph.D. and the Violence Institute of New Jersey for relentless effort and support throughout this investigation. We also thank Gail A. Wasserman, Ph.D. for her assistance.

[1] *N.J.S.A.* 2A:4A-23 defines delinquency as any act that, if committed by an adult, would be a crime, a disorderly persons offense, or a violation of any other penal statute, ordinance or regulation.

[2] *N.J.S.A.* 2A:4A-30. This is generally the case, but exceptions occur. One relevant exception is when a child violates the terms of his or her probation. While not a crime, youth are often held in detention and ordered to new dispositions based upon such a violation. It is also important to note that the Superior Court, Appellate Division, recently ruled that violation of an order in a Family Crisis case cannot be grounds for a delinquency petition. *State ex rel. S.S.* 367 *N.J. Super.* 400 (App. Div. 2004). The New Jersey Supreme Court has granted certification and will rule on this question. *State ex rel. S.S.*, ___ *N.J.* ___ (2004).

[3] *N.J.S.A.* 2A:4A-38. The criteria for placing a child in detention are discussed *infra* at note 33.

[4] *Id*.

[5] *N.J.S.A.* 2A:4A-34.

The judge must then determine whether the youth has violated the law, or adjudicate the youth delinquent.[6] This generally happens either by a child pleading guilty to the charges, or a trial before the judge without a jury. This hearing must be held within 30 days for youth held in county detention centers and shelters, and within 60 days for all other youth.[7]

If a youth is adjudicated delinquent, the court must determine an appropriate disposition, or sentence, for the child.[8] This hearing must be held within 30 days of the adjudicatory hearing for youth held in county detention centers or shelters, and within 60 days for all other youth.[9] The statute governing dispositions gives the court wide discretion in making that determination. Ultimately, the disposition could be probation, mandatory attendance at a program in the community, ordering the child to a DHS residential treatment program, or incarcerating the child in a JJC secure placement such as the State training school.[10] Once a child is disposed and awaiting a non-secure placement, that child must be removed from secure detention to a non-secure facility. *N.J.S.A.* 2A:4A-38.

(1) The Juvenile Justice Commission

The JJC is the single State agency mandated to oversee and operate New Jersey's juvenile justice system. The JJC administers and/or procures a continuum of dispositional placements for youth deemed delinquent by the family court. These placements fall into two general categories: secure placements, such as a State training school in which delinquent youth serve a sentence of time in a locked and guarded facility; and residential group centers, which are less restrictive and located in more community-like settings. Except for one facility which is operated by a private provider under contract with the State, the JJC operates the residential group centers.

Of the 17 county detention centers in New Jersey, 16 are operated by county governments and one is operated by the JJC, under contract with the county.[11] The JJC is the State entity responsible for regulating the county juvenile detention centers, including Atlantic County's, which it operates. Through a series of regulations commonly referred to as the "Manual of Standards,"[12] the JJC has promulgated the minimum requirements for the administration of detention centers. The Manual of Standards regulates the process for admitting a youth to the facility, including an evaluation of the youth's risk for attempting suicide.[13] The Manual requires a registered nurse, or licensed practical

[6] *N.J.S.A.* 2A:4A-38k.
[7] *Id.*
[8] *N.J.S.A.* 2A:4A-41.
[9] *Id.*
[10] *N.J.S.A.* 2A:4A-43.
[11] The JJC operates the Atlantic County Youth Detention Center.
[12] *N.J.A.C.* 13:92-1.1 *et seq.*
[13] The Manual states, "[t]he juvenile shall also be assessed for the risk of suicide in accordance with the facility's written procedures governing suicide screening, prevention and intervention." *N.J.A.C.* 13:92-5.3(a)9.

nurse under the supervision of a registered nurse, to assess each youth's health within 24 hours following admission.[14] The county governments are responsible to operate and fund the detention centers and are responsible for the conditions of care for youth within the detention centers.

(2) The Department of Human Services

Many youth who appear before the family court on delinquency petitions are ordered into placement with the DHS, the single State agency charged to operate the statewide child protection system (known as the Division of Youth and Family Services, or "DYFS") and the children's behavioral health system (known as the Division of Children's Behavioral Health Services, or "DCBHS"). DHS is charged to administer and/or procure a continuum of placements and services for youth deemed by the family court to be in need of protection or mental and behavioral health care. DHS is required to provide these youth with rehabilitative and therapeutic services and placements.

B. Summary of Findings

The prevalence of serious emotional disturbances (hereinafter "SED") among detained youth is not contested.[15] Nationwide, one in five detained youth are estimated to have SED.[16] New Jersey is no exception. A 2001 study of youth ordered into the custody of the JJC revealed that twenty-one percent (21%) of all committed youth presented with SED.[17] With over 11,000 new admissions to New Jersey's detention centers annually,[18] and 935 youth, on average, in detention centers daily, we estimate that at least 200 youth experiencing serious mental health needs are in detention in New Jersey on any given day.[19]

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[14] *N.J.A.C.* 13:92-5.3(a)(10).

[15] "SED is used to refer to youth experiencing more severe conditions that substantially interfere with their functioning. The term 'serious mental health disorder' often refers to specific diagnostic categories such as schizophrenia, major depression, and bipolar disorder. 'SED,' as a term used for youth, includes those youth with a diagnosable mental disorder for whom the disorder has resulted in functional impairment affecting family, school, or community activities." Joseph J. Cocozza, Kathlee R. Skowyra, *National Center for Mental Health and Juvenile Justice, Youth with Mental Health Disorders: Issues and Emerging Response* (2000).

[16] *U.S. Department of Health and Human Services et al., Mental Health: A Report of the Surgeon General.* (1999).

[17] It should be noted that this number rises to approximately 63% when primary diagnoses of substance abuse and disruptive behavior are included. Substance abuse disorders were the most commonly identified diagnoses among the study group, occurring in 48.3% of the participant youth. Disruptive behaviors, which include conduct disorder, were found in 22.9% of youth. Approximately 33% of youth were diagnosed with more than one psychiatric disorder, 15.9% had two diagnoses and 15.5% had three or more. *See Exploratory Analysis of Results of Administration of DISC-IV to Youth at New Jersey Training School for Boys* (2001) (on file with OCA); *see* also Gail A. Wasserman et al, *The Voice DISC With Incarcerated Male Youths: Prevalence Disorder, J. Am. Acad. Child Adolesc. Psychiatry,* 41, 3 (2002).

[18] *Juveniles in Detention Facilities in New Jersey, by Facility-Raw Data, January through December 2003, Juvenile Justice Commission,* on file with OCA.

[19] In 2003, twenty-one percent (21%) of the total admissions to the Arthur Brisbane Child Treatment Center ("ABCTC"), the State's only public youth psychiatric hospital, were referred from the juvenile justice

The prevalence of serious mental health disorders among New Jersey's detained youth is further illustrated by the number of youth in need of psychotropic medication. As part of our detention survey, we asked facility administrators in every county to report the percentage of youth in their centers who were currently taking psychotropic medication. Ten administrators reported that between ten and twenty-five percent (10-25%) of youth housed in their facilities were on psychotropic medication.[20] Three administrators estimated that, on average, one-third of their facilities' residents were taking psychotropic medications.[21] One administrator reported that between forty percent (40%) and fifty percent (50%) of residents were taking psychotropic medication.[22]

Most startling, we learned of over 90 suicide threats or attempts in New Jersey juvenile detention centers from January 1, 2004 through August 30, 2004,[23] a telling indicator of severe mental health distress among youth.

Although children should only be detained in limited instances to promote public safety, youth with low-level offenses, including disorderly persons offenses, and no history of flight or dangerousness, are detained in New Jersey because alternative placements and services are scarce. The primary reason many of these youth are in detention is because the county detention center, unlike the schoolhouse, is the only place that cannot say no. Judges often find themselves confronted with a child whom they deem to be appropriate for a community or non-secure detention alternative, only to find that no such alternative exists, particularly for children with acute mental health needs or children without families. Many of these youth come from unstable homes, where appropriate wraparound services might enable that child to remain in the community, or even that family, while awaiting adjudication, rather than in a detention center. Other youth could live safely in shelters or DHS group homes, rather than county detention, but such placement options are not yet available in sufficient numbers through DHS to meet the need. The overuse of detention for youth with mental and behavioral health needs feeds into the overuse of residential care through DHS and JJC at the dispositional end of the system and makes family reunification that much less likely.

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system. *See New Jersey Office of the Child Advocate, Arthur Brisbane Child Treatment Center Investigation: An Examination of Conditions of Care and Recommendations for Reform* (2004). These numbers speak to both the presence of mentally ill youth within detention and secure facilities, and those facilities' inability to meet youth's mental health needs.

[20] Structured Interview Results (on file with the OCA).

[21] *Id.*

[22] *Id.*

[23] This number is based on critical incident reports and suicide watch information obtained by the OCA from the facilities in Camden, Union, and Essex Counties. Having come from only three of the 17 county detention centers, this number is likely to be vastly under-inclusive of the number of suicide threats and attempts in detention centers statewide. The JJC was aware of only 18 of these incidents, in part because current regulations do not require centers to report most attempts and threats to the JJC. According to the Manual of Standards, county detention centers must provide critical incident reports to the JJC for "all suicide attempts by hanging and all other attempts which require immediate emergency medical attention shall be reported to the Commission as soon as practicable, but no later than within 24 hours of the occurrence." *N.J.A.C.* 13:92- 7.6(b). Our investigation revealed myriad instances in which very serious suicide attempts were not reported to the JJC.

Our investigation confirmed that:

- detention centers are commonly overcrowded;
- youth with mental and behavioral health needs remain in detention for extensive periods of time in violation of the law;
- detention centers are grossly ill-equipped to care for youth with serious mental health disorders;
- time in detention can exacerbate serious mental health disorders in children;
- where youth and families do not have health insurance, or have difficulty accessing mental health services, early intervention and ongoing treatment are far less likely to occur. Unidentified and untreated, a child's behavior may deteriorate until it rises to the level of delinquency.[24] Once an initial contact is made with the juvenile justice system, a youth often becomes categorized as a delinquent as opposed to a young person in need of mental health care.

Our findings, in summary, are:

(1) <u>In direct violation of the law, many detention centers have been required to house more youth than they are designed to hold</u>.

Despite the fact that New Jersey's Code of Juvenile Justice specifically prohibits the placement of any juvenile in a county detention center that has reached its maximum population capacity,[25] overcrowding is a perennial problem for many juvenile detention centers. Already spread thin, facilities struggle to meet even the most basic needs of confined youth when populations surpass rated capacities. Overcrowding yields dangerous conditions within facilities and has been linked to exacerbation of serious mental health disorders in confined youth.

(2) <u>In direct violation of the law, youth are regularly held in detention centers, for extended periods of time, awaiting transfer to non-secure residential programs.</u>

Despite being found appropriate for less restrictive residential and community-based services, many youth are illegally confined to detention for extended periods of time. Juvenile detention is designed to be neither long term nor a placement for children with serious emotional disturbance or behavioral health needs. Nonetheless, many youth languish in confinement, with needs grossly unmet. Our review of detention center records revealed many incidents in which young people displaying symptoms of serious mental health disorder were involved in dangerous interactions with staff or other youth.

[24] *See* M. Grinfield, *Turning Mentally Ill Youth into Criminals, Psychiatric Times*, 2, 17 (2000).
[25] *N.J.S.A.* 2A:4A-37c.

(3) Mental health screening and assessment within youth detention centers are inadequate.

Although thousands of youth in New Jersey's county juvenile detention centers evidence serious mental health disorders each year, very little is done in most detention centers to identify these youth and to measure the extent of their needs. Confinement can exacerbate serious mental health disorders in youth, but in most instances county detention centers are ill-equipped to discern and meet the mental and behavioral health needs of all admitted youth. Failure to identify youth in need of services is dangerous for staff and youth alike.

(4) Mental health care within youth detention centers is grossly inadequate.

Detention is intended to be a short-term setting for youth awaiting more appropriate placements or commitment to the JJC. Historically, social services within facilities have been designed to serve short-term needs. But the presence of children with significant mental and behavioral health needs in detention presents the urgent need for more appropriate mental health and child welfare alternatives, which DHS promises to have in place by July 2005. Until those services are operational and sufficient, the unmet need for comprehensive and substantive mental health services for youth in detention looms large. Because a significant percentage of these youth remain in detention for extended periods of time, it is imperative that specialized and continued care is provided as a short-term but critical service.

(5) Many detained youth are improperly denied Medicaid coverage.

Youth in detention awaiting non-secure placements are entitled to Medicaid coverage, but do not now receive it because of an overly broad exclusion in State regulations. In addition, the state does not presently fund medical services in detention for all youth through the State Medicaid program, though it could and should. The result would be better quality service provision, more uniform systems of care, additional programming, and an up-tick in federal investments of approximately $600,000 annually in the health delivery system for youth.

C. The Background and Jurisdiction of the OCA Investigation

The OCA was created to, among other things:

(1) "seek to ensure the provision of effective, appropriate and timely services for youth at risk of abuse and neglect in the State;"[26]
(2) "inspect and review the operations, policies, and procedures of juvenile detention centers operated by the counties or JJC;"[27] and

[26] *N.J.S.A.* 52:17D-4a.

(3) "review, evaluate, report on and make recommendations concerning the procedures established by any State agency providing services to youth who are at risk of abuse and neglect, youth in State or institutional custody, or youth who receive child protective or permanency services."[28]

The OCA's jurisdiction extends to State juvenile justice facilities and the provision of services, including mental and behavioral health services, to youth detained there. On October 14, 2003, the Child Advocate announced an investigation into the conditions of care for youth detained in juvenile detention centers, including overcrowding, access to mental and behavioral health services and the overall quality of services. The OCA launched its investigation due, in part, to public reports of detention overcrowding and the tragic suicide of E.S. on May 10, 2003, while he was detained at the George W. Herlich Juvenile Detention Center, commonly referred to as the Union County Juvenile Detention Center, which is located on the top level of a parking garage in Elizabeth, New Jersey.[29]

D. The Scope of the OCA Investigation

The OCA's investigation included an examination of the following documents, produced by the JJC:

- Accounting of funds granted to the county Youth Service Commissions (hereinafter "YSCs")[30] and the corresponding project descriptions;
- Monthly and yearly census data from each county detention center for 2001, 2002 and 2003;
- Correspondence between the Union County Juvenile Detention Center and the JJC from January 6, 1998 to December 3, 2003;
- Suicide Critical Incident reports received by the JJC as required by *N.J.A.C.* 13:92-7.6(b).

We also reviewed the following documents produced by the DHS:

- Every Institutional Abuse Investigation Unit[31] referral report from all 17 county juvenile detention centers from January 1, 2003 to October 15, 2004;

The OCA also conducted two assessments. During tours of all county juvenile detention centers conducted during Spring 2004, the OCA staff administered a Structured Interview Questionnaire and a Population and Staffing Questionnaire that we developed

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[27] *N.J.S.A.* 52:17D-5(b)(1).
[28] *N.J.S.A.* 52:17D-5c.
[29] *See* Appendix A (detailing the events leading up to the death of E.S.)
[30] *See infra* Section E, Part 1.
[31] The DHS Institutional Abuse Investigation Unit (IAIU) is responsible to investigate allegations of abuse and neglect in settings, public and private, that provide children with out-of-home care, supervision or maintenance. These settings include, but are not limited to, foster homes, group homes, juvenile detention facilities, treatment facilities, child care centers, public, private and residential schools, shelters, psychiatric hospitals, developmental centers and transportation services.

in collaboration with Dr. Bruce D. Stout, Executive Director of the Violence Institute of New Jersey and the Behavioral Research and Training Institute of the University of Medicine & Dentistry of New Jersey. In addition, facility administrators from each county detention center provided the OCA with the following documents:

- Entries for the most recent 12 months from the Log for the Temporary Restriction of Juveniles required by N.J.A.C. 13:92-6.5;
- Entries for the last 12 months from the Mechanical Restraint Log required by N.J.A.C. 13:92-6.6;
- Any suicide prevention policies and/or procedures;
- Any suicide screening and/or assessment instruments;
- Any mental health screening and/or assessment instruments;
- Reports of medical costs incurred by all facilities in 2003;
- Internal critical incident reports from a limited number of county detention centers; and
- Weekly census data from each detention center from April 2004 to present;

A second assessment, conducted at five detention centers, evaluated the average time youth waited in detention before being transferred to a child welfare or mental health treatment placement between April 1, 2004 and June 30, 2004.[32] The OCA selected the participating counties after the initial round of surveys indicated that the facilities in these five counties had experienced the most recent overcrowding.

In addition to document review and assessments, the OCA interviewed county detention center administrators, staff and detained youth. We spoke at length with executive leadership from the DHS and JJC; experts on serious mental health disorder among youth at large and youth within the juvenile justice population; staff from other states' juvenile justice advocacy organizations and court staff, regarding mental health services for juvenile detainees.

Finally, the OCA evaluated Medicaid eligibility and potential federal revenues to fund health care for detained youth based, in part, on daily cost data provided by DHS, programmatic information provided by the JJC, and extensive program analysis from the New Jersey Department of the Treasury, Office of Management and Budget.

II. INVESTIGATION FINDINGS

A. In direct violation of the law, many detention centers have been required to house more youth than they are designed to hold.

In the Spring of 2004, the OCA requested that each county juvenile detention center provide weekly population census data containing each resident's name, date of birth, admission date, and indicate whether each youth was awaiting placement and, if so,

[32] The five participating counties were Atlantic, Camden, Essex, Mercer and Union.

the type of placement. The data supplied by county detention centers indicates youth often wait extensive periods of time in detention until they are freed to mental health and child welfare placements through the DHS or residential group centers administered by the JJC. The prolonged use of detention to accommodate these waits contributes to detention overcrowding and is in counter to the well-being of children.

Despite the fact that New Jersey's Code of Juvenile Justice specifically prohibits the placement of any juvenile in a county detention center that has reached its maximum population capacity,[33] crowding is a perennial problem for many juvenile detention centers. Five counties reported average daily populations for 2003 that exceeded the rated capacities of their facilities.[34] Since 1993, the average daily population in juvenile detention centers throughout New Jersey has exceeded statewide capacity, but the gap has narrowed dramatically over the years. In 1996, the State, on average, had 410 more detained youth than detention beds on any given day, but by 2002 the bed gap per day was eight statewide. Despite an overall decline in juvenile arrests, the narrowing of this gap owes more to the swelling of bed capacity than to the contraction of the detention population.

Since facility populations can fluctuate significantly over time as cases are adjudicated and placements made, we also asked administrators to report the largest number of youth housed in their facilities over the preceding 12 months**.**[35] The results indicate that eleven facilities reportedly had housed more youth than they were rated to hold during the preceding 12 month period.[36] Administrators most frequently identified the causes of overcrowding in their centers as the inappropriate and prolonged use of detention and the failure of State agencies to place disposed youth in a timely fashion.

We asked administrators: "How many of the youth housed here today have been housed here during this current detention placement for more than 60 consecutive days?" All but two counties indicated that at least one adolescent in population that day had been there more than 60 consecutive days. Essex County had 56 youth in confinement that day who had been in detention more than 60 consecutive days, the largest number in any

[33] New Jersey law provides that "[n]o juvenile shall be placed in a detention center which has reached its maximum population capacity, as designated by the Juvenile Justice Commission." *N.J.S.A.* 2A:4A-37c; *see also N.J.A.C.* 13:92-5.2. In addition to its other statutory duties, the JJC is charged with the regulation of juvenile detention centers. *N.J.S.A.* 2A:4A-37e. The JJC is authorized to cap new admissions to a facility where that facility is regularly overcapacity or in continuous and willful violation of the minimum standards for detention centers. *N.J.S.A.* 2A:4A-37f(1). Upon imposing such a cap, the JJC must determine whether other facilities have adequate space to accept the admissions from the capped detention center, provided that such admissions will not be beyond the maximum rated capacity of these other facilities. *N.J.S.A.* 2A:4A-37f(4).

[34] The problem was most severe in Camden County, where the 2003 average daily population of 91 was two hundred forty-three percent (243%) of capacity. Atlantic, Burlington, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Sussex and Union Counties also indicated that their populations had exceeded capacity in the past 12 months. *See* Appendix C, Table 2. Of these, Essex has made the most dramatic progress in 2004, consistently maintaining a total population well below rated capacity.

[35] Again, the problem was most severe in Camden County, which in August of 2003 housed 131 youth, 354% of the facility's rated capacity of 37 youth.

[36] *See* Appendix C, Table 2.

facility. The Camden County facility housed an adolescent who had been there for 527 days. According to the survey data, nearly one in five detained youth had been confined for more than 60 days. Of the youth who remained in detention beyond 60 days, their average length of confinement was approximately 125 days. Hudson, Morris and Passaic counties held youth in population who had been detained in those facilities for more than 300 consecutive days.

As county detention centers throughout the State have experienced overcrowding, the JJC within the last two years has exercised its authority to cap a facility's population once, in Union County, following the suicide of E.S. at the center in May of 2003. The JJC played a central role in facilitating the removal of the female residents from the Camden County Detention Center this summer, improving that facility's chronic and persistent overcrowding problem. The JJC represents that it has been reticent to impose caps on facilities in part because of its concern that capping detention centers' admissions may place stress on other detention centers in New Jersey by requiring them to admit youth from the capped facility. In addition, capping admissions alone does not solve the underlying problem of over-reliance on detention and underutilization of appropriate detention alternatives. The JJC has addressed overcrowding problems generally by convening the Juvenile Detention Alternatives Initiative ("JDAI"), a promising replication of a nationally utilized initiative which is discussed later in this report.[37]

OCA believes that under appropriate circumstances, particularly where conditions of overcrowding are persistent and present the threat of harm to youth, a cap on admissions can be a necessary act to protect the health, safety and well-being of children in a particular detention center. In the context of this report, where we have identified the inappropriate and illegal detention of certain youth with behavioral and mental health needs as especially problematic, the expansion of procured detention beds prompted by a cap is not a panacea. Children whose primary needs are in the behavioral and mental health care systems, especially the thousands of children whose offenses are minor, should be removed from detention to more appropriate environments, not to detention centers in neighboring counties. However, by enforcing existing statutory provisions regarding the detention of children disposed to non-secure placements, and by increasing the range and capacity of services available through the behavioral healthcare system, the juvenile justice system and child welfare systems could appropriately and safely decrease detention populations.

B. In direct violation of the law, juveniles are regularly held in detention centers, for extended periods of time, awaiting transfer to DHS non-secure residential programs.

With the exception of counties operating JJC-approved programs in which youth adjudicated delinquent may be held post-dispositionally for up to 60 days,[38] county

[37] *See infra* Section II, Part A.

[38] Seven counties have been approved for the 60 day commitment program through the JJC: Bergen, Cumberland, Middlesex, Morris, Ocean, Sussex, and Warren. See Appendix C, Table 10.

detention centers are designed to house youth pre-adjudication and pre-disposition for short periods of time. But the average length of confinement varies greatly across the State. For example, the average length of stay for youth housed in detention centers ranges from a low of 17 days in Bergen County to a high of 55 days in Mercer County, based on all youth detained in 2003.[39] The statewide average length of stay in detention in 2003 was 27 days.[40]

The continued confinement of a youth following disposition to a DHS child welfare or mental health placement is a plain violation of the law. *N.J.S.A.* 2A:4A-38(1) directs that "when a juvenile has been adjudicated delinquent and is awaiting transfer to a dispositional alternative that does not involve a secure residential or out-of-home placement and continued detention is necessary, the juvenile shall be transferred to a non-secure facility." The legislative history of that provision indicates that the Legislature intended to "clarify that if the disposition of [a juvenile] adjudicated delinquent does not involve a secure residential or out of home placement and continued detention is necessary, the juvenile would not be held in [a] juvenile detention facility but [would be] transferred to a non-secure facility."[41] The legislative history also indicates that the provision was based on a recommendation contained in the 1988 report of the Juvenile Delinquency Commission that "[sought] to address the problem of overcrowding in juvenile detention facilities."[42] Given this plain legislative intent to reduce overcrowding, the interpretation of "secure" that best advances the Legislature's goals rests in the common meaning of the word: "[T]o close or confine effectually; to render incapable of getting loose or escaping; as, to secure a prisoner; to secure a door, or the hatches of a ship."[43] Using that interpretation, virtually all out-of-home placements and residential programs for children administered by DHS within the child welfare and behavioral health systems fall within the definition of "non-secure." These are not, and have never been, correctional and guarded programs, confining children in lock-up, as detention does. Indeed, an interpretation of these placements as "secure" settings would require that the Legislature have intended to treat therapeutic placements administered by DHS and secure lock-ups run by the JJC monolithically, which is inconceivable given the statute's purpose. Plainly, disposition by the court to DHS-administered placements triggers the obligation to remove children from the perils of inappropriate detention immediately upon disposition.

Detained youth waiting for a child welfare or mental health placement through DHS are confined, on average, 59 days in county detention centers. They are held even longer than youth sentenced to secure confinement, who are detained a combined average of 54 days in total, nearly a week less than youth headed to a child welfare or mental

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[39] *See* Appendix C, Table 4.

[40] *See* Appendix C, Table 9. The average length of confinement in detention has stayed fairly constant since 1999, when it was 26.5 days. *See Juvenile Justice Commission, Ten Year Trends 1993-2002* (2004). (on file with OCA). In 2000, stays averaged 27 days; 27.5 days in 2001 and 26.6 days in 2002. *See id.* However, over the last 10 years, average confinement stays have increased significantly from 20.4 days in 1993 to 27 days in 2003.

[41] Statement of the Senate Judiciary Committee to Senate Bill 3169 (May 22, 1989).

[42] *Id.*

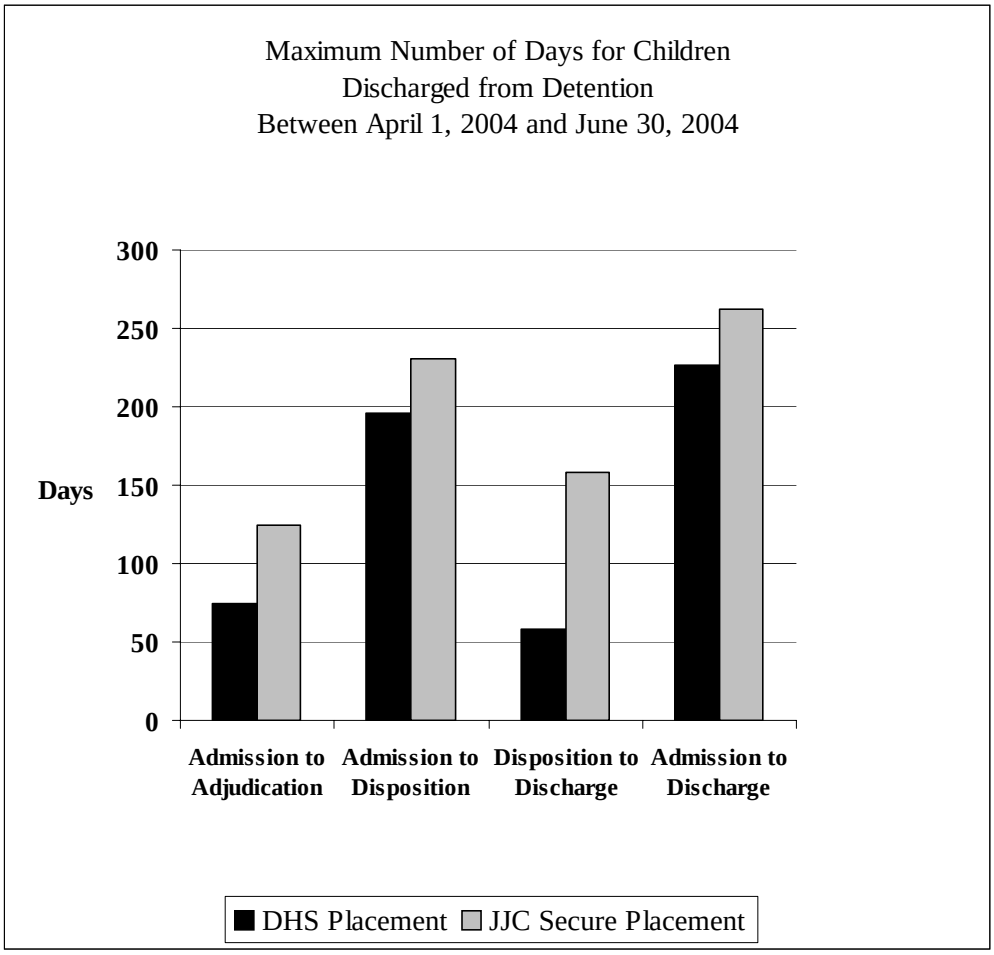
[43] *Webster's Revised Unabridged Dictionary, © 1996, 1998 MICRA, Inc.*

health placement through DHS (Figure 2). The cruel irony is that youth ultimately deemed by the court appropriate for non-secure child welfare or mental health placements through DHS are confined longer in county detention centers than the most acutely delinquent youth sentenced to a term in secure lock-up.

The OCA gathered and analyzed information regarding post-adjudication and post-dispositional lengths of confinement for every youth (113) discharged from detention to DHS child welfare and mental health placements, as well as secure JJC placements, between April 1, 2004 and June 30, 2004, in five detention centers that had experienced overcrowding in the prior 12 months.[44] The youth's placements included 53 child welfare or mental health placements through DHS and 58 secure placements through JJC. This review, reflected in Figure 1 below, found youth waited as long as 227 days in detention for a DHS child welfare placement.

Figure 1

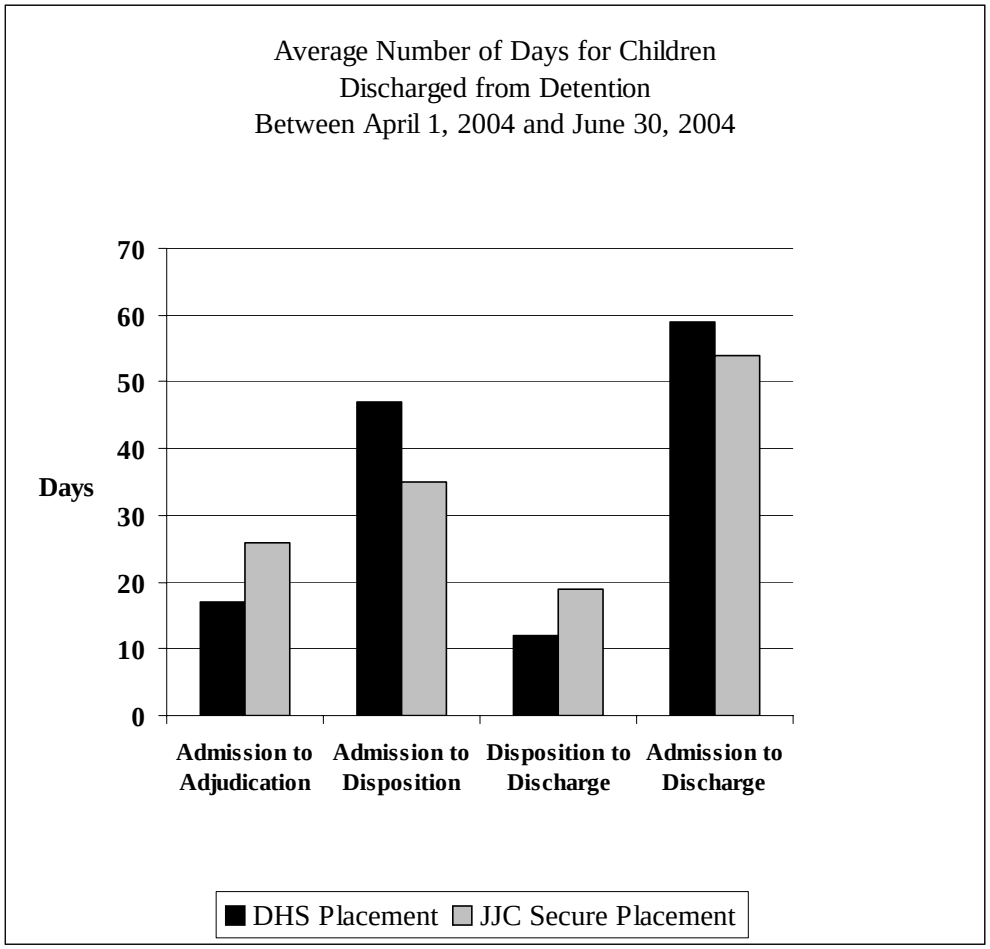
[44] In Camden County, OCA staff reviewed youth's files and recorded data using a standardized tool. Detention center staff at four other facilities (Atlantic, Essex, Mercer and Union) used the same tool developed by the OCA and recorded the data based on their reviews of youth's files. We greatly appreciate the cooperation and efforts of staff at these five facilities.



Twenty-five percent (25%) of youth in detention throughout New Jersey were awaiting a DHS placement, post-adjudication, in the Spring of 2004 when we collected survey data from detention center administrators.[45] Based on our more intensive five county review, the average confinement period for youth from admission to court disposition where courts ordered youth placed with DHS is 47 days, (Figure 2) and the median is 39 days.[46] From the moment a judge orders a youth placed with DHS to the date the placement actually occurs, another 12 days passes on average (Figure 2), for a total combined average confinement period of 59 days for youth waiting for a child welfare or mental health placement with DHS (Figure 2).

Figure 2

[45] *See* Appendix C, Table 7.
[46] *See* Appendix D.



Although youth wait 59 days on average for a DHS placement, when the experience of youth is aggregated by quartile, twenty-five percent (25%) of DHS-disposed youth wait a combined average of 135 days in juvenile detention from admission to placement. For youth with acute mental and behavioral health needs, this equates to over four months of confinement without treatment and services. This group includes many difficult-to-serve and difficult-to-place youth, because of the complexity of their needs and the gaps in New Jersey's care continuum.[47] Nonetheless, despite being found appropriate for less restrictive residential and community-based services, many youth are confined to detention centers, the most restrictive placement available by law, an environment that is not designed or intended to offer long-term mental health treatment services.

Our review of detention center records reinforces reports that county detention centers are forced inappropriately to house youth with SED. Confinement without treatment poses enormous dangers to youth with serious mental health needs, and consumes scarce staff resources to attend safely to a mentally ill child's needs. Detention centers are not equipped to manage youth with mental health disorders. Most employees

[47] *See supra* note 19.

are not properly trained to work with youth with severe mental health needs. The quality and quantity of services necessary to maintain youth's stability are entirely inadequate, and many management issues arise to ensure their safety and that of the general population.

To underscore this point, we have excerpted the following accounts from detention center records to demonstrate the depth and breadth of concerns that accompany the confinement of seriously emotionally disturbed youth.

- In a period of fewer than eight weeks, from June 9, 2004, to July 24, 2004, one resident with acute mental health issues who was sent to the Camden County Youth Detention Center was involved in at least 26 separate critical incidents in the facility.[48] He threatened to commit suicide numerous times, and attempted suicide at least five times. He repeatedly exhibited symptomatic behavior, such as urinating on the floor and showering with his clothes on, in spite of being corrected or reprimanded after each incident. He tried to escape twice by running around the facility unattended. He pulled the fire alarm twice within one hour, and when questioned why he did so, the resident reportedly responded that he is "messed up in the head and can't remember things." One afternoon, while the resident was in isolation, ranting about not wanting a white person to bring his dinner tray, he complained aloud that he feared white people would spit in it, and stated that he would kill them if they did. He then asked a social worker to take him off suicide watch. She agreed to do so if he promised to behave, but he responded by threatening to beat her up. Later that evening while in confined isolation, he was found scratching himself with a piece of putty, which he threatened to swallow. Later still that night, he was observed in isolation with a piece of elastic from his underwear tied around his neck, attempting to hang himself from a light fixture.

- In April 2004, a resident at the juvenile detention center in Union County tried to commit suicide by drinking the chemicals from an ice pack. He was sent for evaluation for a possible placement in a psychiatric unit after being treated. In May 2004, while still detained, it was reported that he was on two different psychotropic medications, and he displayed suicidal behavior on at least four separate occasions. He once threatened to kill himself after a lockdown, resulting in a Juvenile Detention Officer ("JDO") removing the sheets from his room. On another occasion, he was observed with something around his neck, which was eventually found to be a noose made out of paper. Ten days after that incident, he was found in his room cutting his wrist with a sharp, broken plastic cup while covering the window to his room with a shirt. When the cup was taken away, he threatened to hang himself. The following day, this resident was observed with new scratches on his arms. He was found less than two weeks later in his room with a screw in his mouth.

[48] The review included both critical incidents reported to the JJC pursuant to *N.J.A.C.* 13.92-7.6(b) and those generated and maintained by county detention centers for internal use.

Staff members tried to convince him to take the screw out of his mouth, but he swallowed it, and was taken to the hospital. While in detention, the juvenile was also charged with physically assaulting three staff members.

- In May 2004, a 16-year-old youth was admitted to the Passaic County Juvenile Detention Center from a group home. He was transferred to the detention center due to aggressive and inappropriate sexual behavior toward staff at the group home. By mid-September, he had attempted suicide at least 14 times and made numerous suicidal threats. On one occasion, this resident refused to return to his room after assaulting another detainee. He was escorted to his room, where he tied a sheet around his neck. The sheet was removed, and the resident then ripped his jumper and attempted to tie it around his neck. At this point, he was handcuffed, but still managed to rip his t-shirt and try to tie it around his neck while he was restrained. He also displayed symptomatic behavior on several occasions by destroying mattresses so that he could make figurines out of the foam inside them. This resident was on at least two psychotropic medications when he entered the facility, and was maintained on medication while detained. He admitted during an evaluation that his mother was deceased, and he wished he was as well.

Detention administrators routinely identified a delay in placement of youth by State agencies as a cause for long lengths of stay. Administrators also cited time lags between adjudication and disposition as problematic. Although the average time lapse from adjudication to disposition for a JJC or DHS placement is 29 days according to our five county review, a quarter of the youth waited between 40 and 217 days from adjudication to disposition for a State placement.[49] Detention directors in several counties reported that they believed dispositions were delayed until available placement openings were identified.

Juvenile detention centers now serve inappropriately and illegally as placements to confine youth awaiting appropriate placement and treatment through DYFS and DCBHS. These county institutions are not designed to serve this population and they provide grossly inadequate mental and behavioral health care. The prolonged detention of these youth is symptomatic of an acute shortage of residential and community mental health services and treatment options for youth, and points to the urgent need to grow that capacity and strengthen the coordination and cooperation among State agencies, county agencies, and the courts.[50] It is also critical for State agencies to view youth holistically, acknowledging their many and complex needs. Dichotomizing or compartmentalizing

[49] *See* Appendix D.

[50] State officials have identified a lack of mental health and Division of Youth and Family Services (DYFS) beds across the State as a significant problem and asserted that the State is in need of five hundred beds in community mental health programs. *See "Psychiatric Hospital for Youth to be Phased Out by End of 2005", Star Ledger*, May 28, 2004. According to James Davy, Commissioner of DHS, insufficient residential and community resources result in "too many youth…spending too much time in institutions." Testimony of James M. Davy, Commissioner of Human Services, New Jersey Senate, April 7, 2004.

youth as only delinquent, or only in need of child protective services, is shortsighted and harmful to children.

C. Mental Health Screening and Assessment in Youth Detention Centers are Inadequate

Given the disproportionately high number of youth entering county detention centers with mental and behavioral health needs, one would expect a great deal of attention to be focused on identifying need among the population. Unfortunately, this is not the case in New Jersey. Our investigation revealed that screening and assessment practices vary widely among counties, and that formal mechanisms for quality assurance are not routinely in place. This is in part due to the Manual of Standards, which lacks specificity and substance with regard to mental health screening and assessment.[51]

The Manual requires a youth be screened for suicide risk at intake, but the methodology for screening and/or what the screening should entail is not specified.[52] Accordingly, many county detention centers do not use scientifically sound screening instruments or procedures for identifying suicide risk. Detention centers are mandated to create a social services program that includes an initial interview to "assess the emotional needs" of each child entering the facility, provides crisis counseling for youth experiencing sudden or serious emotional problems, and assures an assessment of each youth's problems and needs to plan programs and services.[53] However, there is no guidance as to how this should be accomplished and, as a result, practices vary dramatically across the State, and existing procedures may or may not be consistent with what the mental health field views as "best practices". The Manual requires that psychological and psychiatric services, "be made available for juveniles as needed,"[54] but neither defines "need" nor describes how regularly available services should be. Consequently, practices and substantive services are widely varied at the local level and the vast majority of mentally ill youth have no access to ongoing treatment or therapy.[55]

(1) Mental health screening in youth detention centers is inadequate.

Our investigation revealed only rudimentary activity with respect to mental health screening in most detention facilities.[56] Present screening practice centers primarily on

[51] *N.J.A.C.* 13:92
[52] *N.J.A.C.* 13:92-5.3(a)9.
[53] *N.J.A.C.* 13:92-9.4.
[54] *N.J.A.C.* 13:92-9.5.
[55] *See infra* Section II, Part B.
[56] Limitations in resources were commonly reported by administrators as preventing facilities from probing far beyond initial screens for harm to self or others. When asked if administrators saw value and/or would like to conduct more thorough screenings and assessments on youth, nearly all responded affirmatively. Facilities have authority to deny admission to youth presenting with severe emotional disturbance,

administering a basic suicide risk instrument during a youth's admission to detention. Very few screens in detention centers today are scientifically validated. In the vast majority of detention centers, Juvenile Detention Officers ("JDOs") administer these screens. While it is mandatory and essential that suicide screening be conducted, suicide screens are insufficient to identify other crucial indicators of mental health disorders. In addition to a suicide risk screening, a separate and comprehensive screen is also necessary to detect other immediate needs or concerns a youth may have.

The typical suicide screening instrument used in county detention centers is a questionnaire containing inquiries concerning self-harm. Despite this procedural commonality, the instruments have widely varied levels of sophistication and scientific support. For some centers the suicide risk screening instrument is a stand-alone scale. For other centers, questions designed to measure suicide risk are embedded in a broader mental health assessment instrument.[57] In some counties, suicide risk is assessed based solely on youth's self-reported behavior or ideations.[58] In Atlantic County, for example, the Medical Intake Form includes the questions "Have you ever tried to kill or hurt yourself?" and "Are you thinking about trying to kill or hurt yourself now?" Other counties, including Bergen, Cumberland, Passaic and Sussex, expand on this approach with five or six additional related questions.

A small number of counties employ much more sophisticated suicide screening tools that incorporate multiple items that are known to be predictive of suicide risk.[59] In Gloucester County, for example, a nurse utilizes a 16 item scale to rate the youth's feelings, appearance, behaviors and personal history. Essex County employs a 15 item scale that is based on both observational and self-reported information. The scale includes such risk factors as history of substance abuse, mental health history and legal status. Similarly, Monmouth County employs a suicide risk assessment instrument that incorporates risk factors from various domains, including personal mental health and behavioral histories, substance abuse and appearance. Warren County uses an 11 item instrument to assess risk for suicide.[60] A growing number of counties are implementing a standardized suicide risk screening instrument developed by the JJC. This effort will greatly enhance uniformity of practice.

Perhaps more important than the quality of the screening instrument is the training and expertise of the individual charged with its administration. Individuals who are trained to identify both verbal and non-verbal signs are more likely to identify risk consistently. In most cases, JDOs in New Jersey are provided with little specific training in mental health issues and child development. Thus, even the most well-intentioned JDO may be ineffective or inappropriate in dealing with mentally ill youth. JDOs are required to complete the Police Training Commission requirements at an approved Policy

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intoxication, or medical need. *N.J.A.C.* 13:92-5.2(d). Internal capacity to evaluate beyond these obvious warning signs is often lacking. Structured Interview Results (on file with the OCA)

[57] Structured Interview Results (on file with the OCA).

[58] *Id.*

[59] *Id*

[60] *Id.*

Academy within one year of hire. However, interviews with detention administrators revealed that the standard is routinely violated.

After receiving custody of a child from the delivering law enforcement officer, a JDO must complete a number of procedural steps prior to admitting the youth to detention. The youth must be strip searched, showered, his or her personal items confiscated, itemized and inventoried, and lastly undergo intake interview to collect the youth's demographic information. Questions regarding suicidality occur either as a part of this more general question and answer session or as a separate evaluation. Our survey indicated that in nearly every instance, the same JDO will complete each step of the intake process. Given the nature of the other components of intake, and the likely mental State of the youth at his or her time of admission, there is cause to question the youth's ability or desire to be forthright with the JDO during this final and critical stage of the intake process.

The importance of comprehensive mental health training for staff cannot be understated. Youth with SED present a number of behavioral and emotional needs that can be tremendously difficult to manage. Where facilities are already confronting conditions of overcrowding and its inherent dangers, the additional challenge of managing mentally ill youth can become overwhelming. The result may be the use of unsafe and/or prohibited practices that jeopardize the well-being of staff and youth alike.[61]

It is critical that these screenings be thorough and complete. Rather than only questioning for suicide risk, comprehensive screening tools also probe for a multitude of other potentially harmful or dangerous symptoms. The use of a validated tool has also been shown to reduce instances of human error stemming from insufficient awareness, inadequate education, and/or inappropriate use of discretion.

The JJC is currently facilitating an effort to pilot the use of the Massachusetts Youth Screening Instrument II ("MAYSI II") as a mental health screening tool in seven counties.[62] The MAYSI II is a tool designed by Thomas Grisso, Ph.D., professor at the University of Massachusetts' Medical School, to assist juvenile justice facilities to identify youth during the admission screening process, who have special mental health needs.[63] The MAYSI II is a self-reporting instrument, which asks 52 "yes/no" questions to assess a youth's history and risk for alcohol/drug use, anger and irritability, depression and anxiety, somatic complaints, suicidal ideation, thought disturbance,[64] and whether the

[61] Overcrowding also causes problems with the maintenance of proper staffing ratios. As evidenced in the case of E.S., discussed *infra* in Appendix A, lack of appropriate staffing may lead administrators and staff to take shortcuts and/or begin practices in conflict with established protocol and procedure. The continued and frequent use of "splits," or locking down portions of the population while others are involved with activities, is a clear example of the negative effects overcrowding can have on operations and staff activity.

[62] The seven pilot counties are: Atlantic, Camden, Essex, Hudson, Monmouth, Ocean and Passaic.

[63] The MAYSI is currently being utilized by detention centers in Pennsylvania and Connecticut. Representatives from Pennsylvania's Juvenile Detention Center Association presented on the MAYSI at a pilot "kickoff" conference the JJC convened on June 16, 2004.

[64] This series of questions are male specific.

youth has experienced trauma. It is intended to be administered within 24 to 48 hours of the youth's admission to detention, and to supplement the rudimentary suicide risk assessment that occurs for youth upon admission. Depending on a youth's answers in each behavioral/mental health field, the scores will place the youth in one of three categories**:** the acceptable range, the caution range, or the warning range. A score in the caution range indicates possible clinical significance. A score in the warning range indicates that the score is exceptionally high in comparison to other youth involved with the juvenile justice system.[65] It is important to note the MAYSI has not been validated against psychiatric disorder, and therefore cannot be the only path to trigger an evaluation.[66] The MAYSI is neither intended nor successful at identifying certain types of worrisome disorder.[67]

The pilot utilization of the MAYSI II in detention centers is an important improvement, particularly if "caution" and "warning" scores trigger an immediate and comprehensive mental health assessment. The MAYSI II screening tool is designed so that it can be administered and scored by detention center employees whether or not they have extensive mental health expertise, which is important since the majority of youth admitted to detention centers in New Jersey are screened by JDOs. Statewide utilization of the MAYSI II, or another similarly designed tool, would establish a uniform statewide screening practice, and increase the likelihood that children at risk for suicide, or in imminent need of mental health services, are identified early, perhaps avoiding another tragic adolescent suicide in detention.

The MAYSI II permits detention centers to detect and therefore better manage the needs of detained youth, but it is not a diagnostic tool, and it is not intended to uncover mental health service needs. Rather, the MAYSI II determines whether youth newly admitted to detention have mental and/or behavioral health needs that require immediate intervention.[68] Identifying youth in need of immediate assistance, however, is only the first step. Once youth have been identified as in need of services, it is paramount that follow-up occur and that proper services or referral to DHS be timely provided. It is also

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[65] Both Pennsylvania and Connecticut, two states currently using the MAYSI II to assess youth's needs during the admission process, developed protocols to restrict who may access a child's MAYSI II score. In Pennsylvania, an analysis of state law determined that a child's MAYSI II score may not be released to a probation officer or court personnel unless there is prior written consent or a court order. JDC Association of Pennsylvania, *MAYSI II Policies and Procedures Manual*, 48. Under the general provisions of Connecticut's policies for Juvenile Services Mental Health Screening, "the results of the mental health screen are for planning and treatment purposes only, and are not to be used for the purpose of detention, conviction, or disposition." The policy further states that "the results of the MAYSI are not to be submitted to the Court in the court file or released to attorneys, treatment providers, or other state agencies. A formal request for the MAYSI II results may be made by public defenders, prosecutors, and others with a legitimate interest [pursuant to state law]. Upon such request, the Probation Officer will seek Judicial approval for release of the material." *State of Connecticut Judicial Branch Court Support Services Division Policy and Procedures*, Policy No. 7.30.

[66] *See* Gail A. Wasserman et al, *Mental Health Screening in the Juvenile Justice System: A Comparison Between the Voice-DISC and the MAYSI-2, J. Juv. Just. Det. Servs* (forthcoming) (2004); *see* also Gail A. Wasserman et al, *supra* note 17.

[67] *Id.*

[68] *National Youth Screening Assistance Projects Umass Medical School*, About the MAYSI-II, *at* http://www.umassmed.edu/nysap/MAYSI2 (last visited August 16, 2004).

critical to recognize that some youth in need of an emergency referral also need a referral for on-going mental health services.

(2) Mental health assessment in youth detention centers is inadequate.

We found that full mental health assessments are not regularly conducted for youth in county detention centers, placing youth and staff alike at great risk of harm. Despite the presence of youth with serious mental health disorders in detention, fewer than half of the counties' detention centers regularly employ additional instruments or take further measures to assess mental health or substance abuse problems.[69] County detention centers vary widely in when and how they conduct mental health assessments. Some counties conduct full mental health assessments on all youth admitted to their facilities, others conduct such assessments only when court ordered to do so, or upon indication or observation of acute need.[70] In those counties where need for assessment is based on observation of acute need, there is generally no standardized procedure in place, rather reliance upon non-specialized staff judgment is utilized.

By February 2005, DHS promises that it will assume responsibility for assessing every child in detention within two weeks of admission and every 90 days thereafter. That is not the case presently and counties vary significantly in their internal capacities to conduct mental health assessments. Only four county detention centers (Essex, Monmouth, Morris and Sussex) retain a full-time, mental health clinician capable of conducting complete mental health assessments. The remaining 13 counties report that mental health assessments are conducted either through contract with an outside provider, by a county-employed mental health clinician visiting the facility weekly, or through the county's mobile crisis response team.[71] The availability of these outside providers to conduct assessments and/or treat youth ranged from a psychiatrist who is contracted to visit Warren County for two hours a week to a psychologist who visits Union County three times a week "for as many hours as necessary to meet the need."[72]

Several counties have taken additional steps to assess children's mental health. In Burlington County, for example, the Beck Depression Index[73] is administered by staff social workers within 24 hours of a youth's admission. In Monmouth County, a professionally-certified staff mental health clinician completes a structured interview

[69] Bergen, Burlington, Camden, Middlesex, Monmouth, Ocean, Sussex, and Union Counties indicated that in addition to intake interviews and suicide screening, they employed additional instruments for the purpose of assessing suicide risk, mental health, or substance abuse problems. *See* Appendix C, Table 10.
[70] *See* Appendix C, Table 11.
[71] Notable among this group is Burlington County, which contracts with an organization known as Corr Psych, Inc. with the use of YSC monies.
[72] Interview with Greg Lyons, Assistant Superintendent of the George W. Herlich Juvenile Detention Center in Union County.
[73] The Beck Depression Index ("BDI") is a 21 item self-report rating inventory measuring characteristic attitudes and symptoms of depression. The BDI has been developed in different forms, including several computerized forms, a card form.

with youth. Other centers reported that medical staff asks questions geared at determining mental health wellness during physicals.[74]

As with screenings, assessments are most effective when conducted in-person by a mental health professional.[75] Absent a mental health professional, best practice dictates the use of a proven standardized assessment tool by a well-trained staff member.[76] As discussed previously, though sub-optimal, the use of a standardized tool by a non-clinician will reduce the probability that the needs of youth go unrecognized.[77]

D. Mental Health Care Offered within Youth Detention Centers is Grossly Inadequate.

County juvenile detention centers are not intended to be, and should not become, a means for youth to receive mental and behavioral health services. Nevertheless, youth in detention present with a spectrum of mental and behavioral health needs. For the twenty-one percent (21%) of detained youth who have severe mental health disorders and require acute psychiatric care, detention is never an appropriate placement. However, there is a larger percentage of the general population of youth in detention that present with less severe, yet significant mental and behavioral health issues, most commonly substance abuse and disruptive disorders. Unaddressed, these disorders can manifest in dangerous behaviors and/or jeopardize the well-being of youth. DHS has made a number of commitments to assess every detained youth and serve youth with mental health disorders, though many of the commitments will not be implemented immediately.[78] Accordingly, it is critical that a base competency be developed and maintained within all county detention centers to address and safely house youth with mental health disorders.

The adjustment to detention is difficult for even the most stable young person. For some youth, a night behind bars in detention may be the first spent outside of their home. For others it is yet another institutionalization in a long line of placements. With the addition of a mental health disorder, the experience is likely to be exponentially more traumatic and or challenging to meet. The county detention centers must provide for the

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[74] Structured Interview Results (on file with the OCA).

[75] A mental health professional is defined as a psychiatrist, psychologist or licensed clinical social worker.

[76] *See supra* note 75.

[77] DHS has adopted the use of a needs assessment tool, commonly referred to as the Lyon's Tool, in order to assessment level of care requirements for children referred to the behavioral health care system. We note here that the purpose of that assessment tool is different from the purpose of the assessment for which we are calling. The need for a diagnostic assessment in detention centers that determines type and level of impairment is necessary for the purpose of determining ongoing service needs. The Lyon's Tool does not meet that description. The Diagnostic Interview Schedule for Youth ("DISC") is an example of a standardized assessment tool that has gained some national recognition, though it is certainly not the only instrument option. The DISC is a comprehensive structured interview that covers 36 mental health disorders for youth using DSM-IV criteria. It is available in two formats, one that may be administered by a lay interviewer, and a computerized version with voice instruction that youth complete on their own. The DISC generates an instant diagnostic report, which allows for a thorough understanding of a youth's needs and allows for accurate referral for specialized services. *See Columbia University Department of Child & Adolescent Psychiatry. Diagnostic Interview Schedule for Youth.*

[78] *See infra* Section III.A.

safety and health of these youth while confined, including their basic needs, such as food, clothing, adequate shelter, and medical and mental health care.[79] It is imperative that youth in need of services through the DHS-operated behavioral healthcare system are able to access those services both prior to being charged with an act of delinquency, and afterwards. Educational outreach to inform parents and law enforcement agencies of the availability of DHS resources, such as Mobile Crisis Response Teams, discussed in section III of this report, is an essential step to keeping youth out of the delinquency system initially, and providing services once they have been charged in a delinquency petition.

Prolonged stays in detention for children with mental health needs poses serious threats to the health and safety of detained youth as well as staff. The incarceration of these youth has been linked to increased rates of suicidal and homicidal ideation.[80] Youth with SED learn new behaviors while in confinement in order to survive, behaviors

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[79]The United States Supreme Court has consistently identified the "historic liberty interest" of persons to their own health and well-being. This liberty interest survives even lawful confinement. As the United States Supreme Court has held:

> [W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. . . . [W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fail to provide for his basic human needs--e.g., food, clothing, shelter, medical care, and reasonable safety--it transgresses the substantive limits on State action set by the Eighth Amendment and the Due Process Clause. *DeShaney v. Winnebago Co. Bd. Soc. Servs.*, 489 *U.S.* 189, 200 (1989) (citations omitted).

Youth held by a Court pending adjudication for a delinquency petition may not be held in circumstances that represent a danger to their safety. A child's right to be free from abuse and injury, including injury to their mental health, even in a detention center, is without doubt. *See Youngberg v. Romeo*, 457 *U.S.* 307, 315 (1982); *see also DeShaney*, 489 *U.S.* at 200. Youth in State custody are entitled to receive medical treatment, including mental health treatment, for serious medical needs. *City of Revere v. Mass. Gen. Hosp.*, 463 *U.S.* 239, 244 (1983); *Estelle v. Gamble*, 429 *U.S.* 97, 104-05 (1976). Youth in detention who have not been adjudicated cannot be punished, and any restriction on their liberty must be related to a legitimate purpose other than punishment. *See Bell v. Wolfish*, 441 *U.S.* 520, 535-36 (1979); *see also Ingraham v. Wright*, 430 *U.S.* 651, 671-72 (1977).

A child's liberty interest in his/her personal well-being requires that the State ensure that where a child is in its custody, it appropriately provides for that child's needs. Thus, where a child enters a facility with a serious mental health disorder that requires treatment, the facility cannot ignore that serious mental health disorder and allow that child to suffer. *See, e.g., A.M. v. Luzerne Co. Det. Ctr.*, 372 *F.3d* 572, 584 (3d Cir. 2004) (holding the juvenile detainee had set forth sufficient facts to overcome summary judgment where he had expert testimony that facility lacked adequate policies and procedures to meet his mental health needs). Every detention center must have policies and procedures in place for the provision of mental health services to youth in their facilities. *Id.* at 585. Even more to the point, a facility must adequately train its staff to be aware of behavior that indicates a serious mental health disorder. *Id.* In many cases, youth who are exhibiting symptoms of mental health problems are treated as behavioral problems and punished, rather than given appropriate treatment. This kind of action on the part of a detention center has been found to constitute a violation of minimum constitutional standards. *Id.*

[80] *See Joseph V. Penn, et al. Suicide Attempts and Self-mutilative Behavior in a Juvenile Correctional Facility, Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 762-69 (2003) (concluding that research suggests incarcerated youth have higher rates of suicide attempts and use more violent methods of attempt than youth in the general population.)

that most often manifest in violence and/or aggression.[81] Moreover, there is increasing evidence that detention environments are contraindicated for youth who have been diagnosed with conduct disorder or classified oppositionally defiant.[82] These facts highlight the imperative need to limit the use of detention to those young people who are a risk of flight or dangerous to the community.

The increase in functional service capacity in the DHS behavioral health care system is a vital step towards keeping children out of detention and keeping detention lengths of stay appropriately brief. The development of that system by DHS is not promised until next summer, however. In the meantime detention center administrators and staff are challenged to provide care and custody for many children in need of comprehensive mental health services. While we are sensitive to the concern that increased services in county detention centers may result in a concomitant increased reliance on detention centers for children needing services, the unfortunate reality is that this already happens. Our data indicates a substantial number of youth who require mental health and behavioral health care are being held in detention centers while waiting to access those services. Without question, the most appropriate and therapeutic placement for most of these children is in the behavioral health care and child welfare programs operated by DHS, optimally in the children's own communities throughout New Jersey. But it is also the reality that adequate and sufficient services do not currently exist to meet the needs of these youth, which contributes to their extended confinement in detention.

In order to address the real and present needs of detained youth today, there must be mental and behavioral health services available in detention centers right now. In addition, there are some children for whom detention is necessary based upon statutory factors of risk to the community and risk of flight, but who require mental health services during their time in detention. Thus, there is a need for adequate mental health services in detention centers to meet these needs, not as a place for long-term services, but for management of serious mental health concerns during the course of a child's stay in detention.

In addition, there is marked variability among counties with regard to the level of social services provided within detention centers. Definitional disparity exists throughout the centers as to the qualifications necessary to serve on the social service staff. While the vast majority of centers have "social work" positions, the post does not commonly require an employee to be licensed, to have a degree in counseling or social work, or to possess relevant experience or a history of working with troubled youth. Social services

[81] "The most effective way to turn a non-violent person into a violent one is to send him to prison (which forces him to associate with people who are violent), so it would be essential that only the violent be isolated from the community in this way. People who commit only non-violent crimes do not endanger the *safety* of the public (however much they may inconvenience or annoy it), and there are more effective and constructive ways to deal with their crimes than incarcerating them with those who are violent." *James Gilligan, M.D., The Last Mental Health Hospital, Psychiatric Quarterly*, vol. 72, No. 1 (2002) (emphasis is original).

[82] *Id. See also Deborah Shelton, Failure of Mental Health Policy—Incarcerated Youth; From Research to Policy in Pediatric Nursing, Pediatric Nursing* (2002).

provided by detention social workers are often liaison services, ensuring youth get assessments, visits, phone calls, and make court appearances and other connections with persons outside the facility. In some counties, social workers assist youth in accessing available services by identifying youth in need of services.

Mental health clinical services are highly inconsistent among counties. Only nine of 17 detention centers indicated that they had access to Master's degree level clinicians or higher. Seven of these nine detention centers reported that they employed licensed Master's degree clinicians, and four of those nine counties indicated the presence of Ph.D. level clinicians on staff.[83] Nine counties reported that staff mental health clinicians were certified drug and alcohol counselors.[84]

Access to the limited services that do exist is also problematic. In some counties counseling services are provided to youth who request such services. Other counties provide services upon request by a resident and/or upon referral from a staff member. In Ocean County, in addition to regularly scheduled individual meetings with youth, all youth workers, including the administrator who coordinates the social work department, spend several hours a day on the units informally interacting with the youth. However, most facilities provide their mental health services through contracts with outside providers who have only limited interaction with the youth.

The level of services provided to youth varies from intensive one-on-one counseling for one hour per week with treatment planning to crisis intervention and medication management services only. Six facilities indicated that youth who demonstrate a need for counseling services receive counseling once per week. Nine detention centers indicated either no access to regular counseling from a mental health professional or highly limited access to crisis stabilization services. The remaining facilities indicated that counseling services are available based upon the documented needs of the youth, but did not quantify the level of services available.

In many detention centers in the State, youth suffering from serious mental health disorder, and sometimes severe emotional disturbance, are placed at great risk by the lack of adequate, appropriate, and effective mental health treatment services. Overall, administrators were cognizant of the high levels of need among detained youth and in favor of providing the best assistance resources would permit. To quote one detention center administrator:

> [A]lbeit under a poor set of circumstances, detention presents an opportunity to reach kids; no time in detention should be wasted. As long as we have them here we should do our best to get them stable and try to meet their needs. If we truly hope to have our kids return to society and succeed, it's got to start here. Without services for substance abuse, mental health, and educational

[83] *See* Appendix C, Table 4.
[84] *Id.*

> programming, without addressing the roots, kids walk away having wasted time -- only learning how to be better criminals.[85]

When such vulnerable youth are held in a secure, non-therapeutic environment and do not receive adequate, ongoing mental health care, the damage to that child's psychological functioning can be immense. Failure to meet these needs is analogous to housing a youth suffering from asthma in conditions known to cause serious respiratory distress without providing treatment to prevent a serious attack. By failing to address youth's identified mental health needs, facilities are left to manage youth whose mental state is worsening, sometimes to the point of serious harm to themselves or others.

E. New Jersey currently foregoes significant available federal aid through the Medicaid program to enhance mental health services in detention centers and communities.

(1) Medicaid reimbursement is available for youth detained post-dispositionally while awaiting a child welfare or treatment placement through DHS or a non-secure residential placement through JJC.

A youth's Medicaid eligibility status does not change upon admission to detention. Youth remain eligible for Medicaid[86] while in detention, but the federal rules generally disallow federal reimbursement for medical expenses until a non-secure disposition is ordered.[87] Once a youth has been disposed to a non-secure placement by the court, the youth is in almost all instances plainly eligible for Medicaid, even if the youth remains detained. Accordingly, under federal law, detention centers may seek reimbursement for costs incurred for medical services, including mental health treatment and/or prescription medication, for youth while they await placement in a non-secure placement or program.

Detention administrators routinely identified the costs of health care services for youth confined post-dispositionally but awaiting placement, especially youth with serious mental health disorders, as a major challenge and concern. The cost of psychotropic medication was uniformly identified as a large expense draining resources from other services and programs. Ocean County, for example, reported that the costs of psychotropic medication for one youth exceeded $14,000 over the course of nine months in detention. In all but one instance counties reported that they bear these costs alone,

[85] Interview with Ronald Salahuddin, Director of the Essex County Detention Center (Sept. 9, 2004).

[86] Continuous eligibility enables a youth to receive immediate Medicaid coverage if he/she is transferred to a medical institution (for example, when a detained child is transferred to a hospital) or released.

[87] In addition to detained youth retaining Medicaid eligibility, there are many youth in detention for whom the Medicaid "Inmate Exception" does not apply. These youth are entitled to full Medicaid coverage while in detention and the State is entitled to federal financial participation dollars for services provided for these youth. Federal law states that an individual is not considered an inmate, and therefore is entitled to Medicaid, if he is in a public institution for a temporary period pending other arrangements appropriate to his needs. 42 CFR § 435.1009.

with no reimbursement or contribution from the State or federal government.[88] The impact of these costs is great, with many administrators citing them as a severe budgetary strain that restricts the ability of administrators to provide other appropriate services.

To more fully understand current practice with respect to the Medicaid eligibility of youth in detention, OCA surveyed all county detention centers to determine whether confined youth are terminated from Medicaid and/or whether they receive assistance in applying for, or reactivating, their Medicaid coverage once released. Sixteen facilities responded to the survey.[89] Half of the facilities reported that Medicaid benefits were terminated for detained youth, and the majority stated that youth receive no assistance with enrolling in Medicaid or reactivating their Medicaid coverage prior to release. Whether or not eligibility is affirmatively terminated by DHS in most instances, the fact remains that New Jersey detention centers are eligible for, but are not receiving, Medicaid reimbursement for a substantial portion of the youth in their custody.[90]

The inability of detention centers to obtain Medicaid reimbursement for youth awaiting placement may be a result of New Jersey law, which proscribes reimbursement for inmates of public institutions.[91] Federal law is clear, however, that youth held in detention awaiting a child welfare or mental health placement post-dispositionally are eligible for Medicaid. In 1997, the Health Care Financing Administration ("HCFA") within the United States Department of Health and Human Services explained that youth in detention awaiting placement in a non-secure facility, or awaiting services in their home, are entitled to Medicaid benefits, and States can collect federal financial participation ("FFP") for the physical or mental health services provided. According to HCFA, "FFP is available: … [when] individuals living voluntarily in a detention center, jail or county penal facility after their case has been adjudicated and other living arrangements are being made for them (e.g., transfer to a community residence)." As many youth in detention waiting for "other living arrangements" are awaiting mental health placements, Medicaid is available to pay for the services that they require in the

[88] In Cumberland County, the administrator reported that the local DYFS District Office forwards youth's Medicaid cards to the facility's nurse for the duration of a child's detention. However, the facility budgets for medicine to meet the needs of youth who lack private insurance or are not DYFS involved. In instances when these youth are hospitalized, the facility forwards the bill to the County's Adjustor to resolve.

[89] Mercer County did not respond.

[90] Neither the State nor its counties track Medicaid eligibility data for youth in detention. However, given that the majority of youth in New Jersey's detention facilities are poor, and many are in the child welfare system, there is every reason to believe that a substantial number are Medicaid eligible.

[91] New Jersey's Division of Medical Assistance and Health Services Medicaid Only Manual, states: "(b) Individuals who are inmates of public institutions are *not eligible* for Medicaid coverage, unless they are receiving care in a Title XIX approved section of such facility." Section 10:71-3.14(b) (Emphasis added.) The Manual further states that): "Individuals incarcerated in a Federal, state or local correctional facility (prison, jail, detention center, reformatory, etc.) are *not eligible* for Medicaid coverage. The needs of such individuals (inmates) are met through another agency of the Federal or State government or subdivision thereof." Section 10:71-3.14(c) (Emphasis added.) Similarly, according to New Jersey's subsidized health insurance program regulations, "[A] child who is an inmate of a public institution is ineligible for the NJ KidCare program (NJ FamilyCare Program)." *N.J.A.C.* 10:79-3.11 (a). *See also* N.J.A.C. 10:79-3.11 (b) "[A]ny child who is incarcerated in a Federal, State or local correction facility (prison jail, detention center, reformatory, etc.) is not eligible for the NJ KidCare (NJ Family Care Youth's Program)."

interim. The State, by virtue of federal law, must permit the counties to charge Medicaid for treatment services rendered to eligible youth.

When we asked detention administrators whether youth ordered home or to DHS placements were receiving Medicaid while waiting to leave detention, the response was, universally, "no." In fact, only one administrator knew that youth waiting for non-secure placements were entitled to Medicaid (and the concurrent Early Periodic Screening Diagnosis and Treatment ["EPSDT"] services that Medicaid affords[92]), and only one was aware that federal funding was available to cover the costs of these services.[93] In light of the fact that scores of youth are waiting in detention for mental health placements on any given day and that these youth would benefit tremendously from interim services, it is clear that conditions for detained youth, and the ability of detention centers to meet their needs, could be dramatically improved by infusing these county-operated systems with State and federal resources through the Medicaid program.

By failing to provide Medicaid coverage to entitled, detained youth, that is to say children who stay short spans and children headed to DHS and JJC non-secure placements, the State forfeits federal Medicaid dollars and makes the counties, with their limited budgets, solely responsible for the medical and mental health costs incurred on behalf of youth in detention. Most of these youth have been ordered into the custody of State systems, such as DHS, so New Jersey's current Medicaid practice represents an unfair cost shifting from the State to the counties for the care of youth disposed to the State's legal custody but held in the county's physical custody.

(2) <u>New Jersey should provide Medicaid coverage to all detained youth, including those in detention prior to disposition.</u>

Using the number of youth days in detention and percentage of days spent by youth in post-disposition status, we estimated the total cost and available matching dollars for current medical expenditures by county detention centers. Based on those estimates, the State could cover through its Medicaid program health care for every youth in detention for approximately $3.4 million in State dollars and receive federal matching dollars in the amount of $600,000.[94] Currently, the costs are borne exclusively by the counties and there is no federal investment whatsoever. In addition, by requiring that

[92] EPSDT is a comprehensive Medicaid program designed to provide early intervention and treatment for Medicaid-eligible youth through the age of 21. Under EPSDT, youth are entitled to an array of screening and mental and physical health services, including immunizations and primary pediatric care. 42 *U.S.C.* § 1905(r).

[93] Letter from Mary Previte, Administrator of the Camden County Youth Detention Center to Kevin Ryan, Child Advocate, June 28, 2004, (On file with the OCA). Enclosed with the letter were correspondences dating back to 1976 in which Camden County officials asserted the right to Medicaid reimbursement for youth in detention post-disposition to the Division of Medical Assistance and Health Services.

[94] This conservative estimate is based on the expectation of $275,000 in FFP for post-dispositional youth and at least $325,000 in FFP for Medicaid-eligible youth whose detention is of a short duration. Our survey found that detention centers spent approximately $4 million statewide on medical services in FY2003. While some of this expenditure is not reimbursable through Medicaid, our estimates are that nearly $3.9 million is reimbursable under Medicaid, in federal and state funds, leaving the counties with only those costs that are not eligible for reimbursement.

counties comply with Medicaid regulations for service provision, the State would enhance uniformity and likely improve the overall provision of medical services to youth in detention. The result would be better quality service provision, more uniform systems of care, additional programming, and a significant increase in federal investments in the health delivery system for youth.

Other states around the country have implemented more expansive eligibility and benefit retention policies for youth in detention. For example, in Pennsylvania, "a juvenile placed temporarily in a Juvenile Detention Center is entitled to receive [Medicaid] benefits pending implementation of the court's final disposition."[95] Furthermore, the Commonwealth has instituted a process through which all youth entering detention are automatically enrolled in Medicaid if they are not currently.[96]

Some states continue to provide Medicaid coverage to youth in detention for a limited period of time. For instance, Oregon has instituted an "interim Incarceration Disenrollment Policy." Under this policy, detainees are "dis-enrolled" from Medicaid only after the 15th day of detention. Individuals released prior to the 15th day retain benefits the same way they would if they had never been detained.[97] In addition to providing a 14 day window prior to the termination of benefits, Oregon begins the application/reapplication process for youth while they are in detention and fast-tracks the processing of their cases through the Medicaid office in a day or two.[98] The Medicaid office then faxes temporary Medicaid cards to the detention center so that youth have immediate access to benefits at the time of release. Permanent cards then follow by mail.

Other states, including Massachusetts, have continued to provide Medicaid coverage to youth in detention even when federal dollars are not available. This allows the state to save money by accessing services at reduced Medicaid rates, and frees them of the administrative burden associated with terminating and reactivating Medicaid cases. New Jersey should do the same. -

III. ENCOURAGING DEVELOPMENTS

A. The Child Welfare Reform Plan

In settlement of *Charlie and Nadine H. v. McGreevey*, a federal class action lawsuit filed against the State by Children's Rights Inc., the State committed in 2004 to make a number of substantive changes to its child welfare system. The New Jersey Child Welfare Panel, which oversees the *Charlie and Nadine* settlement reforms, established a timeframe for the State's general commitment to "decrease the number of DYS [sic]

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[95] *Access Guide, Medicaid/Medical Assistances, Physical and Behavioral Health Care Services for Youth Who are Dependent or Delinquent, Commonwealth of Pennsylvania*, 6 (Dec. 2002).
[96] *Id.* at 8.
[97] *The Nations GAINS Center for People with Co-Occurring Disorders in the Juvenile Justice System, Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders.* (Revised Spring 2002).
[98] *Id.*

youth inappropriately placed in detention facilities."[99] The Panel requires "by June 30, 2005 and thereafter, no (0) new youth will be placed in detention centers because of the lack of appropriate placements in the child welfare system, and any youth previously waiting in detention centers are promised to be moved to appropriate alternative placements."[100] OCA intends to vigorously support, monitor and, if required, seek enforcement of this provision of the reform.

On June 9, 2004, Governor McGreevey released "A New Beginning: The Future of Child Welfare in New Jersey" (hereinafter "Plan"), which recognizes that youth are inappropriately held in detention centers and secure confinement, sometimes for months,[101] awaiting a child welfare or mental health treatment placement. The Plan, developed with many stakeholders including the JJC, acknowledges that DHS has a vital role to play in addressing this crisis.[102] This represents an historic break-through among State and county agencies regarding the need for meaningful collaboration to prevent the prolonged detention of mentally ill youth.

The Plan embraces three strategies to eliminate the inappropriate use of juvenile detention for youth awaiting mental health treatment and child welfare placements**.** The first strategy deploys a designated assessment tool to determine the least restrictive environment in which a youth's needs can be met. By February 2005, the State committed to assess every youth in detention. The DHS launched its pilot effort last Spring in response to conditions of severe overcrowding at the Camden County Detention Center, and reports it has now rolled out the assessment to several additional counties.[103] According to an August 13, 2004, letter from DHS, regarding efforts underway at the Camden facility:

> Recently we began a new process in which the Detention Center Social Worker contacts the Contracted Systems Administrator (CSA) to request a clinical evaluation, which includes completion of the needs assessment. This allows for the expedited completion of evaluations on site at the Detention center within the week. With the completion of this information, the CSA can more quickly decide on the most appropriate level of care needed by the child and the

[99] *A New Beginning*, 224, Benchmark 54.

[100] The New Jersey Child Welfare Panel**,** which oversees the overall reform effort, issued the "Enforceable Elements of the New Jersey Child Welfare Reform Plan" ("Enforceable Elements") on July 19, 2004. The document sets forth the elements of the Plan that are enforceable against the State in federal court under the Settlement Agreement. Among the court enforceable provisions is the requirement for DHS**,** as of December 31, 2004, to assign case managers to confined youth who are involved with the child welfare system, but are placed in detention centers because of a lack of appropriate alternative placements. *See Enforceable Element*, Section III(F)(2)(c) (July 19, 2004); *See also A New Beginning*, 224, Benchmark 54.

[101] The State reported that on or about January 20, 2004, there were 67 youth in detention awaiting DYFS or DCBHS placements, and they had been waiting an average of 68 days since entering detention. *See A New Beginning: The Future of Child Welfare in New Jersey*, 103 (June 9, 2004).

[102] *Id.* at 102. The State does not have interim targets for all of its benchmarks due to a lack of baseline data.

[103] *See Enforceable Elements*, 26 (July 19, 2004).

> social worker can make the necessary referrals. This new system should impact tremendously on expediting services to youth both in Detention and the juvenile justice system overall.[104]

DHS also notes that all psychiatric evaluations ordered by the Camden judiciary for detained youth between March 1, 2004, and June 30, 2004, were completed through DHS within one week, a dramatic improvement. By February 2005, according to the Plan, every child in detention will be assessed within two weeks of admission and every 90 days thereafter.

The second strategy builds upon these assessments and calls for transferring the child, when appropriate, to the least restrictive environment. By September 2005, the State will assign case managers to youth in detention awaiting a congregate care placement. DHS, in response to severe overcrowding in the Camden County Detention Center, has also deployed two youth case managers to the center to expedite service provision. The case managers are expected to ensure that all required evaluations occur, identify appropriate placements, transition the child to the identified placement, and locate and coordinate needed community-based services.

In a pilot program, a clinical professional from Youth Advocate Programs Inc. ("YAP") has been working with the families of detained youth in Camden since August 2004 to develop discharge plans for youth, including necessary services for the families to ensure stability. As of November 10, 2004, 13 such plans had been developed and submitted to the court, which accepted all of the plans, leading to the release of those youth. The YAP model, or a similar effort to undertake intensified discharge planning for detained youth and their families, will need to be dramatically expanded in order to impact the thousands of youth statewide who languish behind bars.

By June 2006, the State has promised to expand the capacity of in-home community based services so that youth at risk of being detained due to lack of supervision will have alternative supports available to them.[105] One of the most noteworthy developments from DHS' intensified efforts in the Camden County Detention Center this past year has been the finding that most youth referred to DHS by the judiciary for a residential placement between March 1, 2004 and June 30, 2004, were released to their homes. Only 26 out of 130 detained youth referred to DHS were placed in a DHS residential setting.[106] All of the remaining youth were ultimately discharged to their families with certain services and requirements in place. This could have resulted from a variety of factors, including improved State efforts to provide support services to families in Camden, or, less optimistically, a lack of residential placements that

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[104] Letter from Kathryn Way, Assistant Commissioner, Division of Child Behavioral Health Services, to Kevin Ryan, Child Advocate (August 13, 2004) (on file with the OCA).

[105] By March 2005, the State promises to develop protocols for the police and probation intake staff to access the Mobile Response and Stabilization and Family Crisis Intervention Units when a child has been arrested for a minor offense and his home or placement situation needs to be addressed. *See A New Beginning*, 108 (June 9, 2004).

[106] *Id.*

necessitated alternative arrangements. Regardless of the cause, the success of discharge planning to home for a majority of these youth should be measured against longitudinal recidivism and youth stabilization benchmarks, which the OCA intends to track in certain counties as part of our monitoring function. It also suggests the benefits possible for reunited families if DHS focuses its capacity building not exclusively on a residential continuum but also, as it intends, on the development of supportive services, such as Mobile Response, tailored to support families and recently discharged youth with mental and behavioral health needs.

The DHS has also committed to develop a plan to create community-based alternatives for inappropriately detained youth. The State reiterated this commitment to us in its July 9, 2004, response to our report, "Arthur Brisbane Child Treatment Center Investigation, An Examination of Conditions of Care and Recommendations for Reform." The State promised to "build upon the availability of community supports and services to move youth to appropriate, less restrictive placements in their communities consistent with their needs."[107] Last month, a DHS-appointed task force presented recommendations for *Replacing the Level of Care Provided by the Arthur Brisbane Child Treatment Center*, referring to the State's only public mental health hospital for youth, which is scheduled to close in December 2005. The recommendations were subsequently accepted by the Commissioner and form the basis for an administrative plan to create regional consortia throughout the State offering multiple levels of care for emotionally-disturbed youth, from hospitalization to community-based out-patient supports. A first step in this process includes a proposed contract for acute inpatient services between DHS and the Behavioral Health Services Division of UMDNJ to serve detained youth beginning in January 2005.

Our primary concern is the pace of reform. DHS' commitment to move inappropriately detained youth out of county detention centers altogether upon disposition is historic and commendable. That said, these promises are in such stark relief to current practice that it will require a rapid development of community-based services and placements in order to achieve these vital promises to children by July 2005. It is unclear whether DHS envisions any public sector capacity building, or intends to rely primarily on a network of private providers, but a combination of the two strategies would be the surest way to build the continuum of care in time to meet its commitments under the settlement agreement.

According to the Plan, County Child Welfare Planning groups will analyze how best to serve youth in their communities in need of alternatives to congregate care. By February 2005, the State has promised to create 75 treatment home beds and 45 Emergency Treatment Home beds, and reports presently that it is ahead of schedule in reaching these goals.[108] The State has already funded a new ten-bed program in Voorhees operated by Youth Consultation Services, which provides a new discharge option for detained youth. DHS and the Camden-based Center for Family Guidance are building a detention alternative for youth at Virtua Hospital in Camden City, which will

[107] *Dept. of Human Servs., Response and Corrective Action Plan*, 2 (July 9, 2004) (on file with the OCA).
[108] *See A New Beginning*, 106.

provide treatment and services to the most seriously emotionally disturbed youth in detention centers**.**

The third strategy involves the implementation of practices that promote youth being placed in the least restrictive, most family-like setting.[109] The State has promised to develop protocols to ensure that all court requests for assessment, case planning, or placement, if appropriate, are completed within two weeks of the court's request. Where DHS has initiated its localized first efforts of reform, the results have been promising to date. We recommend, as with all provisions of the Plan that require DHS to respond to the needs of detained youth, that the State prioritize their roll-out by first serving youth in detention centers that have experienced overcrowding.

B. Juvenile Detention Alternatives Initiative

The JDAI is among the most promising developments for inappropriately and illegally detained youth in New Jersey. JDAI, which was brought to New Jersey through the efforts of the JJC, is an initiative of the Annie E. Casey Foundation, with four main objectives: (1) to reduce the number of youth unnecessarily or inappropriately detained; (2) to minimize the number of youth who fail to appear in court or re-offend pending adjudication; (3) to redirect public funds toward successful reform strategies; and (4) to improve conditions of confinement.[110] Over the years, jurisdictions throughout the United States have applied to become JDAI sites, committing themselves to analyze their juvenile justice systems and juvenile detention populations with technical assistance and funding provided by the Casey Foundation, in order to create alternatives to detention.

To achieve the JDAI's four main objectives, successful sites have realized that the process requires a comprehensive analysis of data, rather than reliance upon anecdote, to understand how current practice and previously enacted policies have affected youth involved in the juvenile justice system. In addition, successful sites have learned that collaboration among the stakeholders: members of the judiciary, juvenile justice administrators, detention staff, educators, political leaders, law enforcement, and community advocates is essential for the implementation of enduring and genuine reform.[111]

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[109] *Id.* at 104.

[110] The Annie E. Casey Foundation JDAI at www.aecf.org/initiatives/jdai/ October 6, 2004).

[111] Sacramento, California's Criminal Justice Cabinet, with participants from each agency with criminal justice responsibilities, meets on a monthly basis to address issues pertaining to the juvenile justice population. The Cabinet created the Early Resolution program, which offers youth eligible for community based alternatives the option to have their cases settled earlier and avoid trial. It also improved conditions of overcrowding at the detention center. To implement the program, the prosecutors, public defenders and probation offices each had to be willing to make compromises. In Cook County, Illinois, the JDAI participants, which included members from the executive and judicial branches, originally thought the project would be spearheaded by their executive branch. However upon further review, they determined that the judicial branch should take the lead because probation was housed within the judiciary. The participants developed their risk assessment tool and modified it based on a continuing analysis of which youth were being detained. Ultimately, the Probation Department modified its practice of detaining youth on violation of probation charges automatically for three weeks, by introducing the Detention Alternatives Division, which reviews a child's case after seven days and decides whether to release the child at that

In December 2003, the Foundation notified the JJC that New Jersey had been selected as a JDAI site and five counties[112] were selected to participate in the Initiative. In the first six months of JDAI's pilot implementation, average daily detention populations in all participating counties declined. In addition, a State Detention Reform Core Group, with members from the judiciary, detention centers, prosecutors' offices, the Office of the Public Defender, probation and parole, and other State agencies including the OCA, was established to coordinate and unify efforts underway within the counties and to promote reform necessary at the State level.

C. Mobile Response and Stabilization Services

The DHS Division of Child Behavioral Health Services (formerly the Partnership for Children) established the Youth's Mobile Response and Stabilization Services system ("MRSS") as an "intervention service [that] will be delivered across child welfare, mental health and juvenile justice systems to youth and youth exhibiting emotional or behavioral issues that threaten to disrupt their current living arrangements."[113]

The MRSS has two purposes: first it seeks to de-escalate a youth's crisis on a short-term basis and, second, it implements supports for the youth's long-term stabilization. In order to de-escalate a crisis situation, the mobile response team responds to the child within one hour of receiving the referral and is responsible for providing services over the next 72 hours. Those services are "intended to provide short-term stabilization of a crisis situation that requires intervention to address the presenting behavior, prevent the disruption of the individual's current living arrangement and ensure the immediate safety of the child, youth or young adult and his or her family/caregiver."[114] At the end of the 72 hour timeframe, stabilization services may be provided to the youth in order to monitor and manage formal and informal mental and behavioral health services for a period of up to eight weeks.

As reported by the U.S. General Accounting Office on July 13, 2003, child welfare and juvenile justice officials across the United States estimated that over 12,700 youth in 18 states were placed in those systems in order to access mental health services in 2001.[115] Approximately 9,000 of those youth in those States were placed in the juvenile justice system.

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point or to continue the detention for an additional two weeks. *See Rochelle Stanfield, Pathways to Juvenile Detention Reform, The JDAI Story, Overview, 10-19.*

[112] Atlantic, Camden, Essex, Hudson and Monmouth Counties were selected. With the exception of Hudson County, which will begin participating in the JDAI process within the next few months, the counties have formed working groups and begun gathering data about their county's juvenile detention population.

[113] Section 1.0 Mobile Response and Stabilization Service RFP, §1.0.

[114] *See id.*

[115] The authors of the study believe the numbers are higher, as 32 States, 5 with the largest child populations, did not respond to the study. Additionally, the authors were only able to survey juvenile justice officials in 33 counties nationwide. New Jersey's Middlesex County responded to the survey and estimated that 999 juveniles were placed in the State juvenile justice system in 2001 in order to access mental health services. *United States General Accounting Office, Child Welfare and Juvenile Justice.*

The MRSS is a promising program, offering an alternative to parents and caregivers who in the past sought mental and behavioral health assistance for their youth from the juvenile justice system. The MRSS, which is ostensibly accessible by any community member, including parents, police officers and probation officers, may effectively keep youth with mental and/or behavioral health needs from becoming involved or re-involved with the juvenile justice system, so long as the service is well known and accessed.

In Spring 2004, the OCA staff interviewed detention center administrators, some of whom reported mixed results in their attempts to access MRSS for youth in crisis within the detention center. In Cumberland County, the mobile response team reportedly responded to a call from the detention center, assessed the child, but reportedly did not implement any additional services. In Bergen County, a county-funded mobile response team has historically responded to calls from the detention center. With the implementation of the State-funded MRSS, there were concerns about which mobile response team would or should respond, and whether the State-funded MRSS serves juveniles in crisis while detained.

DHS expanded MRSS coverage into all juvenile detention centers in 2004, and OCA's record review identified several critical incidents at various centers that involved the intervention of MRSS, though these were the exception rather than the rule. There is no evidence yet that MRSS plays a significant statewide role in crisis de-escalation for emotionally disturbed youth in detention. However, this inaugural effort cannot be evaluated fairly this soon, and OCA intends to return to the question of programmatic efficacy within juvenile detention centers after MRSS has been operational for at least 12 months.

IV. RECOMMENDATIONS

Thousands of youth with SED in New Jersey's detention centers are grossly ill-served by a system that fails them in every significant respect. To that end, we make the following recommendations to decrease the time youth experiencing serious mental health disorders stay in county detention centers and to improve the services they receive while in these facilities. Our recommendations are directed to the two primary State agencies responsible for regulating the care of and providing services to this population, the JJC and the DHS, and to counties that operate youth detention centers. While these recommendations specify particular actions needed to remediate the current shortcomings in the system, among the most important steps to reforming the system is better coordination among all the key entities involved in the lives of these young people.

Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Youth Placed Solely to Obtain Mental Health Services, (2003).

Juvenile Justice Commission:

The report demonstrates the need for revision of the Manual of Standards. In particular, the Manual should have more detailed provisions on the evaluation of serious mental health disorder and provision of service to those youth in greatest need. The report also highlights the importance of the JJC exercising its regulatory oversight responsibility as mandated by statute. To that end, the OCA makes the following recommendations:

1. The JJC should immediately enforce N.J.A.C. 13:92-5.2, which forbids the detention of youth in any detention center that has a population exceeding its maximum rated capacity.
2. In order to provide more tools for enforcing regulations than simply restricting new admissions to a detention center, the Executive Board of the JJC should amend its regulations to provide for a graduated system of intermediate sanctions for violations of the Manual of Standards, including, but not limited to:
   - heightened reporting requirements;
   - fines for non-compliance that places children at risk of harm;
   - capacity to authorize an independent entity, or the JJC itself, to take over the management of a non-compliant facility.
   - policy to make public, and post to its web site, all monitoring reports of the county detention centers, including all required corrective actions or imposed penalties.
3. The JJC should every week update and make public, and post to its web site, both the rated census capacity and the average weekly population for every county detention center.
4. The Manual of Standards should be amended to require that every juvenile detention center have a licensed mental health clinician (Psychologist or Licensed Clinical Social Worker) with responsibility for mental health care services pursuant to a written agreement, contract or job description. That clinician should meet with the facility administrator at least once every six months to review policies and procedures for provision of mental health services. The clinician should ensure:
   a. Every youth entering the facility receives an evidenced-based screening by a trained staff member within 12 hours;
   b. Every youth residing in the facility receives an evidence-based mental health assessment by a trained, qualified staff member within seven days of entering the facility;
   c. That ongoing mental health care services are provided to youth who demonstrate need at the screening or assessment;
   d. That psychiatric services are available to youth in the facility on an emergency or crisis basis; and,
   e. That medication is properly distributed and prescribed to youth in the facility in accordance with professional standards.

5. The Manual of Standards should be amended to require that all newly admitted youth be placed on an elevated self-harm watch for the first 48-hours in detention, with attendant proscription that such supervision not include isolation of the youth.
6. The Manual of Standards should be amended to require that all suicide threats and attempts by children in county detention centers be immediately reported to the JJC.
7. The JJC, which has recently expanded the number of Police Training Commission classes, should immediately enforce the requirement that all Juvenile Detention Officers complete Police Training Commission-authorized training within one year of being hired.
8. The JJC should work with the Police Training Commission and consult with experts in the field of juvenile justice and mental health to develop a comprehensive training curriculum for Juvenile Detention Officers and youth workers focusing on the mental health needs of the juvenile detention population, in addition to its existing suicidality curriculum.
9. At present, the JJC is allotted 30 days to complete the process of moving a juvenile from detention to commitment placement. The regulation should be rewritten to call for more expedient transfer from detention to commitment.

Department of Human Services:

The DHS plays a crucial role in making available greater services to youth and in streamlining the process for youth to access those services. In this regard, the Child Welfare Reform Plan is a significant step toward addressing some of the problems addressed in this report. That said, there is no greater priority than moving children out of restrictive jail-like settings if they do not belong there. And hundreds of children in detention today do not. Making children wait in detention for mental and behavioral health services or placements is not responsible, humane or just. Existing resources within the Child Welfare Reform Plan must be prioritized to serve children most in need, and illegally institutionalized and detained children are among those whose need is most exigent. We make the following recommendations:

1. As proposed by the Plan, DHS must create adequate resources for community-based services to free children waiting for DHS services or placements from behind bars. The OCA here again supports DHS's various strategies within the Plan, but the most critical benchmark is the DHS pledge to free children waiting in detention for a DHS placement by July 2005, and never again allow a child to languish there. DHS must ensure it has in place a strategy and implementation plan to achieve those promises. OCA will monitor DHS's progress in achieving this goal in part by conducting a statewide audit of all detention centers in July 2005.
2. DHS should assign clinical staff to every county detention center as quickly as possible, and no later than February 1, 2005, to perform assessments for all youth and make case planning determinations, so as to provide the fastest

possible movement of youth out of detention and into placements and to identify youth appropriate for less restrictive environments and remove them from detention. This program has been effective in moving youth out of detention more quickly in Camden County and should be expanded statewide. We recommend, as with all provisions of the Plan that require DHS to respond to the needs of detained youth, that the DHS prioritize youth in detention centers that have experienced crowding in the last 18 months.

3. DHS should collect data weekly on the number of detained children awaiting a DHS placement in every county detention center, and make public, including posting to its website, the weekly count for every county detention center.
4. DHS should reimburse the counties for the cost of housing and serving youth who have been ordered into the custody of DHS, but who remain in detention for more than one week after such an order.
5. DHS should provide for counseling or other appropriate services for youth who have been ordered into its custody, but who remain in the detention center for more than one week after such an order.

New Jersey Division of Medical Assistance and Health Services, within DHS:

There are a number of steps that New Jersey could and should take to ensure that youth in, and released from, detention facilities receive the Medicaid coverage to which they are entitled. These include the following:

Provide Medicaid coverage to all detained youth, including those in detention prior to disposition;

1. Auto-enroll detained children into Medicaid upon admission to detention.
2. Collect and record Medicaid eligibility and coverage data for youth in the juvenile justice system.
3. Alter the State's Medicaid regulations so that youth entering detention facilities remain eligible for Medicaid while in detention. Issue an all county letter to inform detention facilities of this change.
4. Issue an all county letter confirming that all youth with a placement order for a non-secure setting (such as home or DYFS) are entitled to Medicaid services, if they are otherwise eligible.
5. Create Medicaid "look alike" numbers for all Medicaid eligible youth in detention so that their bills can be sent to Medicaid and payors can pay the lower Medicaid rate for expenses.
6. Develop a process at detention facilities for all youth to complete the Medicaid application/reactivation process prior to release.

Union County:

Consistent with OCA's findings in Appendix A of this report, the George W. Herlich Juvenile Detention Center, commonly referred to as the Union County Juvenile Detention Center, which is located on the top level of a parking garage in Elizabeth, New Jersey, is a substandard and unacceptable facility. The County reports that it intends to construct a new detention center for children, which OCA supports and expects. OCA strongly recommends the County take immediate, significant and affirmative steps to launch its proposed construction project within the next sixty days. OCA intends to monitor the county's progress carefully and to take other steps as necessary and available by statute if significant progress is not forthcoming.

***Multi-Agency Recommendations*:**

1. DHS and the JJC should immediately remove all youth in detention post-disposition awaiting placement in non-secure facilities and place them in less restrictive, more appropriate environments.
2. County officials should immediately create and enact overflow plans to stop the illegal placement of juveniles in facilities that have exceeded rated capacity. To comply with section 2A:4A-37c of the Juvenile Code, which prohibits the placement of any juvenile in a detention center that is beyond capacity, the overflow plans must be designed to trigger any time a facility nears or reaches its rated capacity.
3. Counties should bill DHS for the cost of housing and serving youth who have been ordered into the custody of DHS, but who remain in detention for more than one week after such an order.
4. County officials, JJC and DHS should create a unified system for coordinating services, both inside and outside of juvenile detention centers to ensure that youth's needs are met. They also should ensure that the cost of implementing these added services are properly allocated among the responsible entities. To that end, the DHS and JJC must ensure that county-level coordination and tracking of youth is created and provide county officials with necessary training and protocols on accessing services or support. County officials must use the trainings and protocols to make State actors aware of youth in need of services or placement.