

4-2023

Kids, Cognition, and Confinement: Evaluating Claims of Inadequate Access to Mental Health Care in Juvenile Detention Facilities

Lydia G. Mrowiec

Follow this and additional works at: <https://scholarship.law.wm.edu/wmjowl>



Part of the [Constitutional Law Commons](#), [Juvenile Law Commons](#), and the [Law Enforcement and Corrections Commons](#)

Repository Citation

Lydia G. Mrowiec, *Kids, Cognition, and Confinement: Evaluating Claims of Inadequate Access to Mental Health Care in Juvenile Detention Facilities*, 29 Wm. & Mary J. Race, Gender, & Soc. Just. 691 (2023), <https://scholarship.law.wm.edu/wmjowl/vol29/iss3/5>

KIDS, COGNITION, AND CONFINEMENT: EVALUATING CLAIMS OF INADEQUATE ACCESS TO MENTAL HEALTH CARE IN JUVENILE DETENTION FACILITIES

ABSTRACT

In the United States, almost 60,000 juveniles are incarcerated in juvenile jails and prisons every day, and, as of March 2021, at least seventy percent of juveniles in the juvenile justice system have a mental health condition. For many young adults, prison and detention centers have “become the avenue of last resort” for treatment of those mental health conditions. However, juvenile detention facilities lack the support and resources to provide adequate care, which has led to high recidivism in the juvenile population. Juveniles, and individuals on their behalf, can challenge inadequate access to mental health resources by bringing claims under the Eighth Amendment and the Due Process Clause under the Fourteenth Amendment. In evaluating these claims, federal courts are split on whether to use the Deliberate Indifference Standard or the Professional Judgment Standard, which requires a lower standard of culpability than the Deliberate Indifference Standard. This Note argues that, because juveniles are an extremely vulnerable group, the Professional Judgment Standard should be applied in evaluating claims of inadequate mental health care in juvenile detention facilities. By using this standard, more institutions could be held accountable for inadequate care, which could lead to improved access to mental health care in juvenile detention facilities.

INTRODUCTION

- I. OVERVIEW OF MENTAL HEALTH CARE ACCESS IN THE JUVENILE JUSTICE SYSTEM
 - A. *Defining Juveniles*
 - B. *Current Status of Mental Health in Juvenile Detention Facilities*
 - C. *Implications of Inadequate Mental Health Care in Juvenile Detention Facilities*
 - D. *Screening and Mental Health Diagnoses in Juvenile Detention Facilities*
 - E. *Recidivism*
- II. RIGHTS TO ACCESS TO MENTAL HEALTH CARE FOR JUVENILES IN DETENTION
 - A. *Rights Under the Eighth Amendment*
 - B. *Rights Under the Due Process Clause of the Fourteenth Amendment*

C. *Statutory Sources of Rights to Mental Health Care*

III. TESTS COURTS USE TO ASSESS ADEQUATE MENTAL HEALTH CARE

A. *The Professional Judgment Standard*

B. *The Deliberate Indifference Standard*

C. *Critiques of These Standards*

IV. RECOMMENDATION

CONCLUSION

INTRODUCTION

Lexie Alvarado entered the juvenile justice system when she was only fourteen years old after being arrested for aggravated robbery with a weapon.¹ While incarcerated, Lexie was diagnosed with post-traumatic stress disorder, anxiety, and depression.² Lexie served time at three different juvenile detention facilities, all of which exacerbated her mental health conditions and, ultimately, led to her increased aggression and a propensity to get into altercations.³ At the age of twenty-one, while reflecting on her time in juvenile facilities, Lexie says her mental health deteriorated due to her experience in jail and her emotions were heightened while incarcerated.⁴

In one juvenile facility, Lexie was prescribed psychotropic medication⁵ to “subdue her during the day.”⁶ She describes the facilities as being “really chaotic,” with severe tension between the staff and residents that often led to riots.⁷ Lexie also faced harassment from her peers due to the therapy sessions she received in the facility, and the staff used her trauma to provoke her.⁸

Unfortunately, Lexie’s story is not unique; seventy percent of juveniles in the justice system have a mental health condition.⁹

1. Lindsey Nichols, Hallie Parker & Molly Kruse, *Nearly three-quarters of youth behind bars suffer from mental health issues*, CRONKITE NEWS ARIZ. PBS (Sept. 4, 2020), <https://cronkitenews.azpbs.org/2020/09/04/mental-health-kids-incarcerated> [https://perma.cc/9UCH-Z6PA].

2. *Id.*

3. *Id.*

4. *Id.*

5. Psychotropic medication is used to treat mental health conditions by adjusting the number of neurotransmitters (chemicals) in the brain. WebMD Editorial Contributors, *What Are Psychotropic Medications?*, WEBMD (Apr. 20, 2021), <https://www.webmd.com/mental-health/what-are-psychotropic-medications> [https://perma.cc/834U-54BW]. Psychotropic medication has a higher risk of side effects in children than adults. *See What Is a Psychotropic Drug?*, HEALTHLINE (Nov. 6, 2019), <https://www.healthline.com/health/what-is-a-psychotropic-drug> [https://perma.cc/WZ4M-J5QA].

6. Nichols, Parker & Kruse, *supra* note 1.

7. *Id.*

8. *Id.*

9. *Mental Health By the Numbers*, NAT’L ALL. ON MENTAL ILLNESS, <https://www.nami.org/mhstats> [https://perma.cc/VAJ2-ZRXL] (last updated June 2022).

Many juveniles serving long-term sentences are dependent on psychiatric medication, and it is not uncommon for juvenile detention facilities to medicate juveniles without providing any further resources or therapy.¹⁰ Psychotropic medication does help treat mental health conditions, but it is most effective when combined with psychotherapy.¹¹ However, there is a lack of additional and adequate psychotherapy services for juveniles in detention,¹² and facilities often use medication as a way to restrain juveniles.¹³

Inadequate access to mental health care while in juvenile detention facilities leads to recidivism for many young adults.¹⁴ Xzavier Robertson was first introduced to the juvenile justice system when he was sixteen and was diagnosed with post-traumatic stress disorder, anxiety, borderline dysfunctional disorder, and attention deficit hyperactivity disorder.¹⁵ Just days after his release from detention, he was arrested again.¹⁶ This is common; juvenile offender recidivism rates can be as high as seventy-six percent within three years of release and eighty-four percent within five years of release.¹⁷

When evaluating inadequate mental health care in detention and mental institutions, federal courts apply one of two standards: the Professional Judgment Standard or the Deliberate Indifference Standard.¹⁸ Adequate mental health care is essential in juvenile facilities due to the large number of juveniles suffering from mental health issues,¹⁹ and the concern that juveniles are more likely to reoffend if not given the proper access to mental health care and emphasis on rehabilitation.²⁰ This Note will argue that because of how vulnerable the juvenile population is, which means there is even more of a need to ensure proper mental health care in juvenile detention facilities, courts should apply the Professional Judgment Standard (or even a lower standard of culpability) in cases involving

10. See Nichols, Parker & Kruse, *supra* note 1.

11. WebMD Editorial Contributors, *supra* note 5.

12. See Nichols, Parker & Kruse, *supra* note 1.

13. Ashley A. Norton, Note, *The Captive Mind: Antipsychotics as Chemical Restraint in Juvenile Detention*, 29 J. CONTEMP. HEALTH L. & POL'Y 152, 154 (2012).

14. See Nichols, Parker & Kruse, *supra* note 1.

15. *Id.*

16. *Id.*

17. *Do We Know The Full Extent of Juvenile Recidivism?*, MST SERVICES (Nov. 1, 2018), <https://info.msts-services.com/blog/juvenile-recidivism-rates> [<https://perma.cc/9GKQ-QRVY>].

18. See Sara McDermott, *Calibrating the Eighth Amendment: Graham, Miller, and the Right to Mental Healthcare in Juvenile Prison*, 63 UCLA L. REV. 712, 730 (2016).

19. At least 70% of juveniles in prison have a mental health condition. NAT'L ALL. ON MENTAL ILLNESS, *supra* note 9.

20. See *What Are Juvenile Recidivism Rates and How Can They Be Reduced?*, POINT PARK UNIV. ONLINE (May 25, 2021), <https://online.pointpark.edu/criminal-justice/juvenile-recidivism> [<https://perma.cc/K6PA-K4QD>].

juveniles in detention facilities when evaluating inadequate access to mental health care.

I. OVERVIEW OF MENTAL HEALTH CARE ACCESS IN THE JUVENILE JUSTICE SYSTEM

In the United States, almost 60,000 juveniles are incarcerated in juvenile jails and prisons every day,²¹ and, as of June 2022, at least seventy percent of those juveniles in the prison system have a mental health condition.²² Juvenile detention facilities spend an estimated \$100 million each year to house juveniles awaiting mental health services.²³

A. Defining Juveniles

Section 5031 of the U.S. Code defines a “juvenile” as a person under the age of eighteen, or under the Code for the purposes of proceedings for “an alleged act of juvenile delinquency,” a person under the age of twenty-one (juvenile delinquency is the violation of a law committed by a person under the age of eighteen).²⁴ Each state has its own juvenile justice system and laws involving whether a juvenile is prosecuted as a juvenile (or adult) and placed in a juvenile prison or detention center.²⁵

The Supreme Court of the United States acknowledges the difference in adult and juvenile brains and how brain development impacts culpability.²⁶ Juveniles’ brains are structurally and chemically different from adult brains because the human brain continues to mature into a person’s mid-twenties.²⁷ Because of the structural and chemical characteristics of their brains, juveniles tend to be more impulsive, easily influenced by others, have mood swings, and

21. *America’s Addiction to Juvenile Incarceration: State by State*, AM. CIV. LIBERTIES UNION, <https://www.aclu.org/issues/juvenile-justice/youth-incarceration/americas-addiction-juvenile-incarceration-state-state> [https://perma.cc/2P2F-KGTB] (last visited Apr. 13, 2023).

22. NAT’L ALL. ON MENTAL ILLNESS, *supra* note 9.

23. SPECIAL INVESTIGATIONS DIVISION STAFF OF H. COMM. ON GOV’T REFORM, 108TH CONG., INCARCERATION OF YOUTH WHO ARE WAITING FOR COMMUNITY MENTAL HEALTH SERVICES IN THE UNITED STATES I (2004) [hereinafter H. COMM. ON GOV’T REFORM], <https://www.hsgac.senate.gov/imo/media/doc/040707juvenilereport.pdf> [https://perma.cc/9G8E-ASTJ].

24. 18 U.S.C.A. § 5031 (West).

25. Norton, *supra* note 13, at 155.

26. *Adolescent Brain Development*, COALITION FOR JUV. JUST., <https://www.juvjustice.org/our-work/safety-opportunity-and-success-project/national-standards/section-i-principles-respon-din-10> [https://perma.cc/FL7C-89VL] (last visited Apr. 13, 2023).

27. *Id.*

have stronger or weaker reactions to situations than adults.²⁸ Additionally, the Supreme Court recognized that adolescence is “a time and condition of life when a person may be most susceptible to influence and to psychological damage.”²⁹ Taking into account these biological features, access to mental health care is especially important for juvenile brain development.³⁰

B. Current Status of Mental Health in Juvenile Detention Facilities

A study prepared by the U.S. House of Representatives Committee on Government Reform—Minority Staff Special Investigations Division, found that in a six-month period, almost 15,000 juveniles in juvenile detention facilities waited for community mental health services, representing about seven percent of all youth in juvenile detention.³¹ Of those 15,000 juveniles waiting for mental health services, two-thirds had attempted suicide or attacked others while in the facilities.³² The juveniles in the detention facilities were also as young as seven years old.³³ From this report, it is very apparent that juvenile detention facilities in the United States are not equipped to provide adequate mental health care.³⁴

Individuals in juvenile detention facilities are even more vulnerable to mental health conditions than juveniles in general.³⁵ The prevalence of mental health conditions is three times higher in the juvenile justice system than in the general juvenile population.³⁶ Ninety-two and a half percent of incarcerated juveniles report exposure to accidents, physical and sexual abuse, serious illness, and violence, all of which can trigger mental health conditions including, depression, anxiety, and post-traumatic stress disorder.³⁷

28. *See id.*

29. *Eddings v. Oklahoma*, 455 U.S. 104, 116 (1982).

30. “Good mental health helps [juveniles] develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults.” *Children and young people*, MENTAL HEALTH FOUND. (Aug. 12, 2021), <https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/children-and-young-people> [<https://perma.cc/5UEN-LGTN>].

31. H. COMM. ON GOV'T REFORM, *supra* note 23, at i.

32. *Id.* at ii (One administrator reported, “Youth who are banging their head or fist or feet into walls or who are otherwise harming themselves must be restrained creating a crisis situation. . . . [C]onsequently detention staff have to divert all resources to that one youth for an extended period of time.”).

33. *Id.* at i.

34. *See id.*

35. *Groups with Increased Risk*, YOUTH.GOV, <https://youth.gov/youth-topics/youth-suicide-prevention/increased-risk-groups> [<https://perma.cc/9DME-74AE>] (last visited Apr. 13, 2023).

36. *Id.*

37. OFF. OF JUV. JUST. AND DELINQUENCY PREVENTION, INTERSECTION BETWEEN MENTAL HEALTH AND THE JUVENILE JUSTICE SYSTEM 1, 4 (2017), <https://ojjdp.ojp.gov/mpg/literature-review/mental-health-juvenile-justice-system.pdf> [<https://perma.cc/ZJS8-FN8K>].

Young women in juvenile detention facilities are more likely than their male counterparts to suffer from mental health diagnoses and more severely.³⁸ Young women also particularly suffer from anxiety disorders and post-traumatic stress disorder.³⁹ Additionally, the rate of young women in juvenile detention facilities has also increased at a faster rate than for young men.⁴⁰ Furthermore, young women in juvenile detention facilities attempt suicide at a higher rate than their male counterparts.⁴¹ It is estimated that, of the juveniles in detention facilities, just under thirty percent had attempted suicide.⁴² In general, juveniles in detention are four times as likely to commit suicide than juveniles in the general population.⁴³

The juvenile justice system disproportionately affects individuals of color; two-thirds of individuals in the juvenile justice system are juveniles of color.⁴⁴ Additionally, Black and Brown juveniles are less likely than white juveniles to receive contact with a mental health professional while incarcerated.⁴⁵

C. Implications of Inadequate Mental Health Care in Juvenile Detention Facilities

For many young adults, juvenile detention facilities have “become the avenue of last resort” for treatment of their mental health conditions.⁴⁶ However, juvenile detention facilities lack the support and resources to provide adequate care, which has led to high recidivism in the juvenile population.⁴⁷ Often, spending time in juvenile

38. Eighty-one percent of young women in juvenile prisons suffer from mental health conditions, whereas 66.8% of young men in juvenile prisons do. Kira Pyne, *Mental Health in Youth Facilities*, COALITION FOR JUV. JUST. (May 13, 2020), <https://www.juvjustice.org/blog/1163> [<https://perma.cc/69U9-ETHM>].

39. NAT'L CONF. OF STATE LEGISLATURES, MENTAL HEALTH NEEDS OF JUVENILE OFFENDERS 4 (2007), <https://www.legis.iowa.gov/docs/publications/SD/6694.pdf> [<https://perma.cc/UQC8-UEB3>].

40. THE SENTENCING PROJECT, INCARCERATED WOMEN AND GIRLS 1, <https://www.sentencingproject.org/app/uploads/2022/11/Incarcerated-Women-and-Girls.pdf> [<https://perma.cc/2MQH-2TDA>] (last updated May 2022).

41. Nichols, Parker & Kruse, *supra* note 1.

42. *Id.*

43. YOUTH.GOV, *supra* note 35.

44. Forty-one percent are Black and 21% are Hispanic. *The State of America's Children 2021*, CHILD. DEFENSE FUND, <https://www.childrensdefense.org/state-of-americas-children/soac-2021-youth-justice> [<https://perma.cc/68PB-SSQJ>] (last visited Apr. 13, 2023).

45. OFF. OF JUV. JUST. AND DELINQUENCY PREVENTION, *supra* note 37, at 6.

46. See Elizabeth Bonham, Kathleen R. Delaney, Geraldine S. Pearson, Deborah Shelton & Joan Darby Thomas, *Meeting the Mental Health Needs of Youth in Juvenile Justice* 2 (Feb. 6, 2008) (Int'l Soc'y of Psych. Nurses, position paper).

47. OFF. OF JUV. JUST. AND DELINQUENCY PREVENTION, *supra* note 37, at 4–5.

detention facilities exacerbates juveniles' mental health conditions.⁴⁸ Juveniles in detention facilities are often put in forced isolation (solitary confinement).⁴⁹ Isolation may be used in attempt to reduce violence, because the facilities lack proper accommodations, or "for [the juvenile's] own protection."⁵⁰ However, there is no evidence that placing juveniles in isolation reduces violence, and may in fact cause it to increase.⁵¹ Isolation can have severe psychological effects including causing depression, panic attacks, paranoia, anxiety, anger, hallucinations, and obsessive thinking.⁵² Additionally, juveniles of color, LGBT+ juveniles, gender-nonconforming juveniles, and juveniles with disabilities are placed in isolation more frequently than other juveniles.⁵³ Because of the still developing brains of juveniles, it is important to continue ongoing assessment and treatment of their mental health conditions, and not use isolation as a way to attempt to deal with mental health conditions in detention facilities.⁵⁴

D. Screening and Mental Health Diagnoses in Juvenile Detention Facilities

The National Commission on Correctional Health Care (NCCHC) provides guidelines for juvenile detention facilities on a yearly basis.⁵⁵ However, facilities do not always adhere to these guidelines.⁵⁶ The NCCHC requires that all juveniles be screened for physical and mental health concerns when entering the detention

48. See Nichols, Parker & Kruse, *supra* note 1 (describing how Lexie Alvarado's time in juvenile prison worsened her aggressive behavior, and she was diagnosed with post-traumatic stress disorder, anxiety, and depression).

49. Thirty-five percent of juveniles in prison are put in forced isolation. OFF. OF JUV. JUST. AND DELINQUENCY PREVENTION, CONDITIONS OF CONFINEMENT 9 (2010), <https://www.ojp.gov/pdffiles1/ojdp/227729.pdf> [<https://perma.cc/T2ME-G8GY>]. Juveniles in solitary confinement are typically held in a cell for 23 hours a day without interaction with other juveniles in the facilities or access to books, educational services, or other activities. Pyne, *supra* note 38.

50. *Solitary Confinement & Harsh Conditions*, JUV. L. CTR., <https://jlc.org/issues/solitary-confinement-other-conditions> [<https://perma.cc/7PP6-PS7G>] (last visited Apr. 13, 2023).

51. See *id.*

52. See Sandra Simkins, Marty Beyer & Lisa M. Geis, *The Harmful Use of Isolation in Juvenile Facilities: The Need for Post-Disposition Representation*, 38 WASH. U. J.L. & POL'Y 241, 254 (2012).

53. *National Report Finds Solitary Confinement Harms Youth and is Unevenly Applied*, AM. BAR ASS'N (Oct. 1, 2017), https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol-36/sept-oct-2017/national-report-finds-solitary-confinement-harms-youth-and-is-un [<https://perma.cc/NK5S-SYWH>].

54. See NAT'L CONF. OF STATE LEGISLATURES, *supra* note 39, at 5.

55. Pyne, *supra* note 38.

56. See *id.*

facility, but only sixty-one percent of juveniles reported having a mental health screening.⁵⁷ The screening is used to identify any potential psychiatric problems and current medications the individual is taking.⁵⁸ The NCCHC also requires that, during the screening, a treatment plan be developed for the individual by a mental health professional, documented, and communicated to the facility staff.⁵⁹ NCCHC also advises that (1) medication regimes the individual is already on are not interrupted; (2) any psychiatric symptoms should be treated; (3) psychotropic medication⁶⁰ be used only to treat mental illness and not used to “control behavior”; (4) the facility have adequate suicide prevention measures; and (5) referrals to mental health care outside of the facility should be provided.⁶¹

While the NCCHC requires adequate suicide prevention measures, seventy-seven percent of juveniles in facilities report having access to mental health counseling, but only fifty percent had access to suicide risk reduction services,⁶² and seventy-five percent of detention facilities have inadequate suicide prevention procedures in place.⁶³ Also, contrary to the NCCHC guidelines, juveniles in detention are often heavily prescribed psychotropic and antipsychotic medication.⁶⁴ While psychotropic medication can be helpful, it can increase the risk of suicide in young adults.⁶⁵ Juvenile detention facilities use antipsychotic medication to “restrain children” and “correct” their behavior, but not in the way antipsychotics are intended to be used or for which the actual mental health conditions the medications are intended.⁶⁶

Additionally, the staff in the facilities providing service are often inadequately trained.⁶⁷ Fifty-four percent of staff in juvenile detention facilities report receiving “poor, very poor, or no mental health training,” and some receive as little training as a single seminar.⁶⁸

57. *Id.*

58. Rani A. Desai, Joseph L. Goulet, Judith Robbins, John F. Chapman, Scott J. Migdole & Michael A. Hoge, *Mental Health Care in Juvenile Detention Facilities: A Review*, 34 J. AM. ACAD. PSYCHIATRY & L. 204, 207 (2006).

59. *Id.*

60. *Id.*

61. *Id.*

62. Pyne, *supra* note 38.

63. Simone S. Hicks, Note, *Behind Prison Walls: The Failing Treatment Choice for Mentally Ill Minority Youth*, 39 HOFSTRA L. REV. 979, 986 (2011).

64. Eight to ten percent of juveniles in the general population are prescribed psychotropic medication, whereas 50% of juveniles in custody are prescribed them. See Norton, *supra* note 13, at 162.

65. See *id.* at 153.

66. See *id.* at 153, 154.

67. Hicks, *supra* note 63, at 987.

68. H. COMM. ON GOV'T REFORM, *supra* note 23, at 10 (A Tennessee administrator said, “Upon admission we screen for mental illness, but the only training we’ve received is

Administrators at facilities often report being frustrated with outside services needed in the cases of hospitalizations.⁶⁹ The outside mental health service providers often say that the juvenile is “better off” in the juvenile detention facility than an inpatient unit.⁷⁰ There are also long waits to be seen by outside counselors, juveniles may be refused to be seen without a parent present, and the outside counselors may tell the facility staff that the juvenile is their problem.⁷¹ On the off chance mental health care is available in the juvenile detention facility, because of the high turnover rate, it is not the appropriate place for long-term care.⁷² Inappropriate treatment often leads juveniles to reoffend.⁷³

E. Recidivism

Most juveniles in juvenile detention facilities have not been accused of violent crimes.⁷⁴ For these nonviolent offenders, juvenile detention facilities often cause them “more harm than good.”⁷⁵

Juvenile offenders are more likely to reoffend than adult offenders.⁷⁶ Juvenile offenders have a recidivism rate as high as seventy-six percent within three years and eighty-four percent within five years.⁷⁷ Studies have found that juvenile detention programs that focus on intervention rather than incarceration can reduce recidivism.⁷⁸ These programs focus on mental health including family therapy and aggression replacement training.⁷⁹

a seminar,” and a North Carolina administrator noted, “This population is very difficult to manage due to staff not being trained adequately to deal with mental health issues.”).

69. *Id.*

70. *Id.*

71. *See id.* (A Texas administrator said when dealing with a juvenile who had “auditory and visual hallucinations and [was] homicidal/suicidal,” they were told hospitalization was needed, but “it would be at least a month before he could even see the psychiatrist. He was not of top priority because he was in a secure environment. The psychiatrist then refused to see him without a parent present. I explained that the court had placed him in our care. . . . I was told this was my problem.”).

72. *See id.*

73. *See* Nichols, Parker & Kruse, *supra* note 1.

74. Out of 2,000,000 juveniles arrested in 2008, 95% had not been accused of violent crimes (murder, rape, aggravated assault), and of 100,000 convicted in 2010, 26% had committed property crimes only. *See* DAVID GOTTESMAN & SUSAN WILE SCHWARZ, NAT’L CTR. FOR CHILD. IN POVERTY, JUVENILE JUSTICE IN THE U.S. FACTS FOR POLICYMAKERS 1 (2011), https://www.nccp.org/wp-content/uploads/2020/05/text_1038.pdf [<https://perma.cc/X5QG-HHST>].

75. *Id.*

76. *See* POINT PARK UNIV. ONLINE, *supra* note 20.

77. *Id.*

78. *See id.*

79. *See id.*

Additionally, access to adequate mental health care for juveniles while in detention facilities may help decrease the chances of youth reoffending.⁸⁰ Longitudinal studies have shown that mental illness in juveniles is linked to an increase of risk in recidivism, and thirty to fifty percent of juveniles with mental illness in the justice system reoffend within six months of being released.⁸¹ Often these individuals get “stuck in the ‘revolving door’ of the juvenile justice system, in which they are repeatedly arrested, detained, released, re-arrested, and redetained.”⁸²

Increased contact with the juvenile justice system and reincarceration is one of the highest risk factors leading to adult incarceration.⁸³ This cycle can lead to lifelong incarceration.⁸⁴ Increased recidivism requires more taxpayer money to go to juvenile detention facilities to house youth and long-term effects on juveniles may lead to their lower productivity in society.⁸⁵ Additionally, recidivism or untreated mental illness can be harmful to the country as a whole because the individuals may not be able to work and do not pay taxes while incarcerated.⁸⁶

Because of the prevalence of mental illness among juveniles in detention facilities and inadequate treatment measures by these facilities, courts need to step in to evaluate proper care.⁸⁷

II. RIGHTS TO ACCESS TO MENTAL HEALTH CARE FOR JUVENILES IN DETENTION

A. Rights Under the Eighth Amendment

The Eighth Amendment of the Constitution states: “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”⁸⁸ Courts interpret the Eighth

80. See GOTTESMAN & WILE SCHWARZ, *supra* note 74, at 1.

81. See Laura M. White, Katherine S. L. Lau & Matthew C. Aalsma, *Detained Adolescents: Mental Health Needs, Treatment Use, and Recidivism*, 44 J. AM. ACAD. PSYCHIATRY & L. 200, 200 (2016).

82. *Id.*

83. See *id.* at 200–01.

84. See *id.* at 201.

85. See GOTTESMAN & WILE SCHWARZ, *supra* note 74, at 1.

86. Darcel Rockett, *Untreated traumas in arrested juveniles linger 15 years past incarceration, Northwestern study finds*, CHI. TRIB. (Apr. 27, 2021, 5:08 PM), <https://www.chicagotribune.com/living/health/ct-health-youth-incarceration-psychiatric-disorders-0427-20210427-mi5b4s6i3zdoxn52ds5agixppy-story.html> [https://perma.cc/L8KY-L98X].

87. See, e.g., *DeShaney v. Winnebago Cnty. Dept. of Soc. Servs.*, 489 U.S. 189, 200 (1989) (“[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.”).

88. U.S. CONST. amend. VIII.

Amendment as applying to the justice system in three ways: “First, it limits the kinds of punishment that can be imposed on those convicted of crimes . . . ; second, it proscribes punishment grossly disproportionate to the severity of the crime . . . ; and third, it imposes substantive limits on what can be made criminal and punished as such.”⁸⁹

Inadequate access to mental health care for juveniles in detention facilities has been argued to constitute “cruel and unusual punishment.”⁹⁰

The constitutional right to appropriate treatment of juveniles in detention facilities was first articulated by the U.S. District Court of Rhode Island in *Inmates of Boys’ Training School v. Affleck* where the court held that placing juveniles in isolation cells constituted cruel and unusual punishment.⁹¹ Following this case, *Martarella v. Kelley*, applied the Eighth Amendment regarding cruel and unusual punishment of juveniles in a detention center.⁹² Cases of Eighth Amendment complaints on behalf of juveniles in detention facilities are usually about overcrowding, inadequate medical care, inappropriate use of isolation or punishments, or lack of services including access to mental health care or education.⁹³

The U.S. Supreme Court has stated that “when 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.”⁹⁴ In applying this line of thought, in *Estelle v. Gamble* the U.S. Supreme Court held that access to medical care for individuals in prison falls under an individual’s Eighth Amendment right.⁹⁵ However, the application of the Eighth Amendment rights is often limited by the Deliberate Indifference Standard described in Part III.⁹⁶

Another limitation to succeeding in an Eighth Amendment claim is that courts have limited individual’s medical care needs to “only . . . those that are ‘serious.’”⁹⁷ But federal appellate courts,

89. *Abdool v. Bondi*, 141 So. 3d 529, 547 (Fla. 2014) (quoting *Ingraham v. Wright*, 430 U.S. 651, 667 (1977)).

90. Thomas L. Hafemeister, *Parameters & Implementation of a Right to Mental Health Treatment for Juvenile Offenders*, 12 VA. J. SOC. POL’Y & L. 61, 90 (2004).

91. *See id.* at 84–85; *Inmates of Boys’ Training Sch. v. Affleck*, 346 F. Supp. 1354, 1366–67 (D.R.I. 1973).

92. *See Martarella v. Kelley*, 349 F. Supp. 575, 598 (S.D.N.Y. 1972).

93. Hafemeister, *supra* note 90, at 85–86.

94. *DeShaney v. Winnebago Cnty. Dept. of Soc. Servs.*, 489 U.S. 189, 199–200 (1989).

95. *See Hafemeister, supra* note 90, at 88.

96. *See id.* at 89.

97. *See id.* (citing *A.M. ex rel. J.M.K. v. Luzerne Cnty. Juv. Det. Ctr.*, 372 F.3d 572, 584 (3d Cir. 2004)).

such as the Fourth Circuit have expanded Eighth Amendment rights to include mental health treatment, stating in *Bowring v. Godwin*, "We see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart."⁹⁸ Based on this, juveniles in detention facilities can bring their claims of inadequate access to mental health care under the Eighth Amendment, but the Eighth Amendment is not their only option, they can also bring a claim under the Fourteenth Amendment.⁹⁹

B. Rights Under the Due Process Clause of the Fourteenth Amendment

Section 1 of the Fourteenth Amendment states:

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.¹⁰⁰

Courts have used two bases under the Due Process Clause of the Fourteenth Amendment to argue the right to access to treatment.¹⁰¹ The "quid pro quo" theory was advanced in *Morales v. Turman* that held that "the state is charged with a statutory duty to provide 'a program of constructive training aimed at rehabilitation and reestablishment in society of children adjudged to be delinquent.'"¹⁰² Under this theory, juveniles in custody are supposed to receive rehabilitative treatment because they receive fewer procedural protections than adults.¹⁰³

The second theory uses the right to substantive due process and is often referred to as the *parens patriae* rationale.¹⁰⁴ The U.S. Supreme Court has held that "the nature and duration of commitment bear some reasonable relation to the purpose for which the

98. *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977).

99. See Hafemeister, *supra* note 90, at 90–91.

100. U.S. CONST. amend. XIV.

101. Paul Holland & Wallace J. Mlyniec, *Whatever Happened to the Right to Treatment?: The Modern Quest for A Historical Promise*, 68 TEMP. L. REV. 1791, 1798 (1995).

102. *Morales v. Turman*, 383 F. Supp. 53, 71 (E.D. Tex. 1974) (quoting TEX. REV. CIV. STAT. ANN. art. 5143d (1971)).

103. See Holland & Mlyniec, *supra* note 101, at 1799; Hafemeister, *supra* note 90, at 92.

104. See Hafemeister, *supra* note 90, at 91.

individual is committed.”¹⁰⁵ Because the main purpose of juvenile detention is rehabilitation, it follows that in order to provide rehabilitation, juveniles must be provided adequate access to mental health.¹⁰⁶ The rights under the Fourteenth Amendment may be broader than under the Eighth Amendment as the courts use a different test to analyze Fourteenth Amendment claims (as described in Part III).¹⁰⁷

C. Statutory Sources of Rights to Mental Health Care

Juveniles can also bring claims for inadequate treatment for mental health conditions under the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, and the Civil Rights of Institutionalized Persons Act (CRIPA).¹⁰⁸ The CRIPA is used for claims “involving deprivations of rights of institutionalized persons,” and includes juveniles under the list of individuals protected by the Act.¹⁰⁹

III. TESTS COURTS USE TO ASSESS ADEQUATE MENTAL HEALTH CARE

There are two tests courts use to assess the adequacy of mental health care treatment in juvenile detention facilities: the Professional Judgment Standard (or *Youngberg* Standard) and the Deliberate Indifference Standard.¹¹⁰

A. The Professional Judgment Standard

The Supreme Court announced the Professional Judgment Standard as being derived from the Fourteenth Amendment in *Youngberg v. Romeo*.¹¹¹ Under this standard, “liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”¹¹² This standard has a lower standard of culpability than the Deliberate Indifference Standard

105. *Jackson v. Indiana*, 406 U.S. 715, 737 (1972).

106. *See Hafemeister*, *supra* note 90, at 91.

107. *See id.* at 92.

108. *See id.* at 101, 102.

109. Civil Rights of Institutionalized Persons Act, Pub. L. No. 96-247, 94 Stat. 349 (1980).

110. *See McDermott*, *supra* note 18, at 730.

111. *Id.*

112. *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982).

(described in Part II) and requires more than negligence.¹¹³ Under this standard, facilities are not liable for improper treatment due to budgetary constraints.¹¹⁴

In *Youngberg v. Romeo*, a thirty-three-year-old with a mental disability was involuntarily committed to a mental institution.¹¹⁵ While in the institution, he was injured by his own actions arising from both his illness and from actions of other residents.¹¹⁶ While being treated for these injuries, he was “physically restrained.”¹¹⁷ His mother filed a suit on his behalf claiming his constitutional rights to proper conditions of confinement and freedom of bodily restraint were violated.¹¹⁸ The Court held that under the Fourteenth Amendment, her son was entitled to safe conditions, the facility could not use unreasonable bodily restraints, and most importantly, the state had a duty to provide adequate medical care to individuals while in the facility’s care.¹¹⁹

Since *Youngberg*, the Court has articulated that the nature of the facility the individual is housed in is secondary (meaning the individual does not have to be housed in a mental facility for the standard to apply).¹²⁰ Rather, the Professional Judgment Standard can be applied to individuals in prison and detention centers.¹²¹

Recently, in *Doe 4 by and through Lopez v. Shenandoah Valley Juvenile Center Commission*, the Fourth Circuit applied the Professional Judgment Standard to a case involving a juvenile detention center housing unaccompanied immigrant children.¹²² In the course of three years, at least forty-five juveniles housed in the facility attempted suicide.¹²³ The facility’s commission argued that the Professional Judgment Standard did not apply to their facility because it was a juvenile detention center and “not a hospital or therapeutic setting.”¹²⁴ The Court rejected the Commission’s distinction reiterating from *Matherly* that “the nature of the facility is not dispositive,”

113. See *Doe 4 by and through Lopez v. Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d 327, 343 (4th Cir. 2021).

114. See *Youngberg*, 457 U.S. at 322.

115. *Id.* at 309.

116. *Id.* at 310.

117. *Id.*

118. See *id.* at 312.

119. See *id.* at 324–25.

120. See *Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 341 (describing *Matherly v. Andrews*, No. 16-6473 (4th Cir. 2017), in which the Court applied the Professional Judgment Standard to an involuntarily committed sex offender in prison).

121. See *id.* at 329, 339.

122. See *id.*

123. *Id.* at 333–34.

124. *Id.* at 341.

and allowed the Professional Judgment Standard to be applied to juvenile detention centers.¹²⁵ The dissent argued that the Professional Judgment Standard should not have been applied because it created a circuit split, and the Deliberate Indifference Standard is an intentionally “high bar” that is rarely met.¹²⁶ But this Note disagrees with the dissent and argues that based on the current mental health crisis and prevalence of inadequate mental health treatment in juvenile detention facilities, a lower bar is necessary to hold facilities and officials accountable in order to improve conditions.

B. The Deliberate Indifference Standard

The Deliberate Indifference Standard imposes a higher standard of proof of culpability than the Professional Judgment Standard.¹²⁷ This test is a two-prong test¹²⁸ that requires a plaintiff to show that the detainee had a serious medical condition¹²⁹ or it was “sufficiently obvious” that a person without a medical background could recognize the condition¹³⁰ (objectively) and the official or facility knew the detainee’s needs and disregarded them (subjectively).¹³¹ The *Farmer v. Brennan* court described the second prong as “civil-law recklessness,” which is unlike criminal recklessness in which a person is reckless only when they disregard a risk of harm of which they are aware.¹³² Under the Deliberate Indifference Standard, an official cannot be found liable under the Eighth Amendment “unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.”¹³³

This standard also does not require that a risk come from a single source or multiple sources, or whether the risk is personal to one individual or to all prisoners in that situation.¹³⁴ The burden to show that the official did not have knowledge of the risk is on the official.¹³⁵ However, even if an official did have knowledge of a

125. *Id.*

126. *See Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 349.

127. *See id.* at 343 (referring to the Deliberate Indifference Standard as “the higher standard”).

128. *See McDermott*, *supra* note 18, at 751.

129. *See Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

130. *McDermott*, *supra* note 18, at 732.

131. *Farmer*, 511 U.S. at 837.

132. *Id.*

133. *Id.*

134. *See id.* at 843.

135. *See id.* at 844.

substantial risk, the official can be free of liability if the official responded “reasonably” because under the Eighth Amendment, the official’s duty is to provide “reasonable safety.”¹³⁶

The Supreme Court articulated the Deliberate Indifference Standard in *Farmer v. Brennan* where a transgender woman in an all-male prison filed a complaint that the prison had failed to protect her by placing her in general population where she was harmed by other inmates.¹³⁷ The Court used the Deliberate Indifference Standard to hold that the officials could be liable under the Eighth Amendment for inhumane conditions only if they knew that the woman faced a substantial risk of harm and disregarded that risk by failing to take action to prevent the harm.¹³⁸ The Court drew this conclusion by stating that the Eighth Amendment “does not outlaw cruel and unusual ‘conditions’; it outlaws cruel and unusual ‘punishments,’” so an act or omission by a prison official is something that should be “discourage[d],” but it is not an “infliction of punishment.”¹³⁹ The Court reasoned that a completely objective standard was not appropriate; a claimant needs to show that a prison official acted despite his knowledge of the risk of harm, and the official failed to act.¹⁴⁰ The Court also assessed that a subjective approach would not motivate prison officials to act in a way that ignored obvious risks.¹⁴¹

Courts have applied the Deliberate Indifference Standard to juveniles in juvenile detention centers such as in *A.M. ex rel. J.M.K. v. Luzerne County Juvenile Detention Center*, where a juvenile detainee (through his mother) sued the detention center for failing to protect him from harm.¹⁴² Prior to arriving at the center, the juvenile, A.M., had been diagnosed with anxiety disorder, depressive disorder, atypical bipolar disorder, Attention Deficit Hyperactivity Disorder (ADHD), and intermittent explosive disorder, all of which the center’s administrators were aware.¹⁴³ However, A.M. did not receive medication until after his psychiatric evaluation, which was eleven days following his arrest.¹⁴⁴ Throughout A.M.’s time in the center, he was assaulted multiple times by fellow juveniles, often due to his untreated mental illness, “which included teasing and provoking other residents.”¹⁴⁵

136. *See id.*

137. *See Farmer*, 511 U.S. at 829–30.

138. *See id.* at 828–29.

139. *Id.* at 837, 838.

140. *Id.* at 842.

141. *See id.*

142. *A.M. ex rel. J.M.K. v. Luzerne Cnty. Juv. Det. Ctr.*, 372 F.3d 572, 577 (3d Cir. 2004).

143. *Id.* at 576.

144. *Id.* at 575–76.

145. *Id.*

When A.M. did receive a psychiatric evaluation, it showed he had ADHD and was “considerably influenced by delusions or hallucinations or serious impairment in communication or judgment . . . or inability to function in almost all areas.”¹⁴⁶ Following the evaluation, A.M. did start to receive medication for his ADHD; however, he was never seen by another health professional.¹⁴⁷ The psychiatrist also had recommended a “highly planned day” and the administrators recommended transferring him to the girls’ side of center to avoid contact with the male juveniles who had assaulted him.¹⁴⁸ The staff failed to abide by these directions on multiple occasions, and A.M. was stabbed by a juvenile in the center.¹⁴⁹

In assessing the adequacy of A.M.’s mental health care treatment at the center, the court applied the Deliberate Indifference Standard.¹⁵⁰ In applying the standard, the court granted summary judgment to the general physician and registered nurse at the center, on claims against them in their individual capacities, holding they did not act with deliberate indifference in their failure to disseminate information about A.M.’s mental health history to the staff at the center and the physician was not required to conduct an evaluation of A.M.¹⁵¹

The court also directed that the Deliberate Indifference Standard be applied in evaluating whether the center had adequately trained its employees, stating that it can be a constitutional violation if “the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need.”¹⁵² The court could not hold that the center was deliberately indifferent “as a matter of law,” but determined there was enough issue of material fact for a jury to decide.¹⁵³

Although the district court in the case held that there was insufficient evidence of the center’s deliberate indifference to A.M.’s access to mental health care, the court of appeals held that there was enough evidence to provide an issue of material fact, by presenting expert testimony of a psychiatrist.¹⁵⁴

146. *Id.* at 576 (quoting AM. PSYCH. ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 32 (4th ed. 2000)).

147. *Id.*

148. *A.M. ex rel. J.M.K. v. Luzerne Cnty. Juv. Det. Ctr.*, 372 F.3d 572, 576 (3d Cir. 2004).

149. *See id.* at 577.

150. *See id.* at 581–82.

151. *Id.* at 579–80.

152. *Id.* at 582 (quoting *City of Canton v. Harris*, 489 U.S. 378, 389–90 (1989)).

153. *Id.* at 583 (quoting *Berg v. Cnty. of Allegheny*, 219 F.3d 261, 277 (3d Cir. 2000)).

154. *See A.M. ex rel. J.M.K.*, 372 F.3d at 584–85.

In *Blackmon v. Sutton*, a juvenile pretrial detainee was often restrained in a restraint chair to prevent self-harm but also as punishment and was not provided adequate medical attention.¹⁵⁵ Additionally, Blackmon alleged that the facility failed to provide him adequate mental health care against the mental health unit supervisor and the facility's counselor.¹⁵⁶ The court analyzed the adequacy of mental health care under the Deliberate Indifference Standard.¹⁵⁷ The facility professionals accepted that Blackmon's mental illness was obvious to a reasonable person, but they argued that because they were not licensed health professionals, they could not provide care to Blackmon.¹⁵⁸ The court rejected this argument and stated that officials who have "gate keeping" authority over mental health professionals in the facility can also violate the Eighth Amendment by failing to provide access to care.¹⁵⁹ Because the facility professionals had considerably delayed in providing Blackmon with access to a psychologist after he exhibited suicidal and self-harm actions and no treatment was provided after the consultation with the psychologist, there was enough evidence to deny qualified immunity for the facility professionals.¹⁶⁰

In *Mangum v. Repp*, a twelve-year-old boy was sexually assaulted by a fellow juvenile, who had been committed for rape and gross sexual imposition of children between the ages of six and eight, in a juvenile corrections facility.¹⁶¹ Mangum's initial assessment determined that because he had been sexually abused in the past, he was considered a "high-risk/need offender," and was placed in the intensive mental health unit of the facility.¹⁶² Mangum argued that the facility officials had shown a deliberate indifference to his safety by housing him with an individual who has been committed for rape, especially as Mangum was susceptible to sexual abuse.¹⁶³ While the court acknowledged that under *Farmer*, "prison officials have a duty . . . to protect prisoners from violence at the hands of other prisoners," but noted an official violates an individual's rights only if the official is "deliberate[ly] indifferen[t] to inmate health or safety."¹⁶⁴

155. See *Blackmon v. Sutton*, 734 F.3d 1237, 1239 (10th Cir. 2013).

156. *Id.* at 1244.

157. *Id.*

158. *Id.* at 1245.

159. *Id.* (quoting *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980)).

160. See *id.*

161. *Mangum v. Repp*, 674 F. App'x 531, 532–33 (6th Cir. 2017).

162. *Id.* at 532.

163. See *id.* at 537.

164. *Id.* (quoting *Farmer v. Brennan*, 511 U.S. 825, 833 (1994)).

Under the first prong to the Deliberate Indifference Standard, the facility officials did not dispute that Mangum was exposed to a “substantial risk of serious harm” by being housed in a unit with a convicted sex offender.¹⁶⁵

Under the second prong of the standard, the court articulated that Mangum had to present evidence that the officials “(1) subjectively perceived facts from which to infer a substantial risk of serious harm to plaintiff, (2) actually drew the inference that there was a substantial risk, and (3) disregarded that risk.”¹⁶⁶ The court held that the facility psychologist was subjectively aware of the substantial risk because he treated both Mangum and the young man who assaulted him, and Mangum had reported potential threats from his assaulter to the psychologist.¹⁶⁷ However, the court held that a reasonable juror could not have inferred that the psychologist disregarded the risk because he “took reasonable steps” in response to the risk posed, such as putting Mangum on a safety plan, requiring one-on-one staff monitoring, always seating Mangum near officers or teachers, and there was no evidence that the psychologist knew the plan was not working at the time of the assault.¹⁶⁸ Mangum argued that the psychologist “should have done more,” but the court held that their inquiry was only on whether the psychologist’s response was reasonable, not on what he could have done.¹⁶⁹

C. Critiques of These Standards

Scholars argue that courts should alter the Deliberate Indifference Standard because of the unique nature of juveniles.¹⁷⁰ Levick argues that in cases of juvenile confinement, courts should “account for the unique juvenile vulnerability to harm in confinement” when assessing the objective prong of the Deliberate Indifference Standard.¹⁷¹ This would mean that a plaintiff needs to prove less harm in order to show the need for protection.¹⁷²

In regard to the subjective prong of the Deliberate Indifference Standard, Levick argues that a criminal negligence standard “that imposes liability when the prison official disregards an obvious risk”

165. *Id.* (quoting *Farmer*, 511 U.S. at 834).

166. *Id.* at 538 (citing *Farmer*, 511 U.S. at 837, 839).

167. *See Mangum*, 674 F. App’x at 538.

168. *Id.* at 538–39.

169. *Id.* at 540.

170. *See McDermott*, *supra* note 18, at 751.

171. *Id.*

172. *See id.*

is more appropriate for juveniles in prison, and that a subjective test “undermine[s] the requirement implicit in a rehabilitative system.”¹⁷³

There is concern about providing access to mental health treatment in juvenile detention facilities clashing with state interests because of the potential costs associated with it.¹⁷⁴ Yet, the Fourth Circuit has stated that care is “limited to that which may be provided upon a reasonable cost,” which would ultimately then not create an undue burden on states.¹⁷⁵ There is also contention regarding whether the Eighth Amendment rights apply to juveniles in detention centers who have not been sentenced or yet found guilty, but the court has applied the Eighth Amendment rights to pretrial detainees as in *Blackmon*.¹⁷⁶

IV. RECOMMENDATION

Because juveniles entering detention are an extremely vulnerable group with a prevalence of mental health conditions,¹⁷⁷ the Professional Judgment Standard (or even a lower standard of proof of culpability) should be used in evaluating claims of inadequate mental health care in juvenile detention facilities. This lower standard would hold more institutions accountable for inadequate care, likely leading to a higher standard of mental health care, which would follow a model of emphasis on rehabilitation, not of punishment.¹⁷⁸

Because of inadequate mental health care, juveniles have been put in danger,¹⁷⁹ injured by other juveniles in facilities,¹⁸⁰ sexually assaulted,¹⁸¹ exhibited self-harm, and attempted suicide.¹⁸² Nevertheless, where courts have applied the Deliberate Indifference Standard, the juvenile detention facilities and staff often are not held accountable.¹⁸³ Although judges may be reluctant to use the

173. *Id.* at 752–53 (quoting Marsha Levick, Jessica Feierman, Sharon Messenheimer Kelley & Naomi E. S. Goldstein, *The Eighth Amendment Evolves: Defining Cruel and Unusual Punishment through the Lens of Childhood and Adolescence*, 15 U. PA. J.L. & SOC. CHANGE 285, 313–14 (2012)).

174. *See* Hafemeister, *supra* note 90, at 90.

175. *See* Bowring v. Godwin, 551 F.2d 44, 48 (4th Cir. 1977).

176. *See* Blackmon v. Sutton, 734 F.3d 1237, 1244 (10th Cir. 2013).

177. Nichols, Parker & Kruse, *supra* note 1.

178. *See, e.g., Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 348 (Wilkinson, J., dissenting) (“the professional judgment standard expands the role of the courts in overseeing mental healthcare in juvenile detention centers”).

179. *See, e.g., Farmer v. Brennan*, 511 U.S. 825, 853, 854–55 (1994).

180. *See, e.g., A.M. ex rel. J.M.K. v. Luzerne Cnty. Juv. Det. Ctr.*, 372 F.3d 572, 576 (3d Cir. 2004).

181. *See, e.g., Mangum v. Repp*, 674 F. App’x 531, 532 (6th Cir. 2017).

182. *See, e.g., Blackmon v. Sutton*, 734 F.3d 1237, 1245 (10th Cir. 2013).

183. *See Farmer*, 511 U.S. at 837–38 (stating that an omission by a prison official should be discouraged but is not “infliction of punishment”); *A.M. ex rel. J.M.K.*, 372 F.3d

Professional Judgment Standard because they prefer the “high bar” for culpability of the Deliberate Indifference Standard, ultimately favoring defendants,¹⁸⁴ this is something that can likely be overcome, as seen in *Shenandoah Valley Juvenile Center Commission*.¹⁸⁵

Courts may be concerned that in holding more juvenile detention facilities accountable and to a higher standard, the facilities will need to completely reform how they treat mental health conditions and spend a substantial amount of money in the process.¹⁸⁶ However, appropriate mental health care is essential in rehabilitation and decreasing recidivism.¹⁸⁷ In the long run, by reducing recidivism, juvenile detention facilities could reduce the current \$100 million they spend each year to house juveniles awaiting mental health services.¹⁸⁸ These funds are not being adequately used by detaining juveniles that are better suited for inpatient treatment.¹⁸⁹

Additionally, these standards need to be analyzed under a lens that takes into account juveniles’ brain development.¹⁹⁰ By not holding juvenile detention facilities accountable for their treatment of juveniles, some courts would be failing to adhere to their position that adolescence “is a time and condition of life when a person may be most susceptible to influence and to psychological damage,”¹⁹¹ and “criminal procedure laws that fail to take defendants’ youthfulness into account at all would be flawed.”¹⁹²

In 2004, even though the House of Representatives Committee of Government Reform—Minority Staff Special Investigation Division study concluded that inadequate access to mental health care in juvenile detention facilities is a “serious national problem,” there has not been improvement.¹⁹³ The Committee also recognized that

at 580 (finding insufficient evidence of deliberate indifference to a juvenile’s access to mental health care); *Mangum*, 674 F. App’x at 538–39 (finding a psychologist not liable because he took “reasonable steps”).

184. See *Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 349.

185. See *id.* at 339.

186. See McDermott, *supra* note 18, at 757 (quoting Aaron Sussman, “[h]olding the Court to its theory as properly applied to the conditions within juvenile justice systems . . . would entail economic and political costs so substantial that they virtually ensure such an application to be a non-starter”).

187. See GOTTESMAN & WILE SCHWARZ, *supra* note 74, at 1.

188. See *APA Statement on Reforming the Juvenile Justice System to Improve Children’s Lives and Public Safety*, AM. PSYCH. ASS’N (2010), <https://www.apa.org/news/press/statements/juvenile-justice> [<https://perma.cc/TH5J-TLQZ>].

189. An administrator reported, “We are receiving juveniles that 5 years ago would have been in an inpatient mental health facility. . . . [W]e have had a number of juveniles who should no more be in our institution than I should be able to fly.” See H. COMM. ON GOV’T REFORM, *supra* note 23, at ii.

190. See McDermott, *supra* note 18, at 752.

191. See *Eddings v. Oklahoma*, 455 U.S. 104, 115 (1982).

192. *Graham v. Florida*, 560 U.S. 48, 76 (2010).

193. See H. COMM. ON GOV’T REFORM, *supra* note 23, at 15.

“[i]nappropriate detention is dangerous for youth and the staff of detention centers and is costly to society,” and changes were “urgently needed.”¹⁹⁴

CONCLUSION

Unfortunately, juvenile detention facilities have become an alternative to mental health care facilities for juvenile offenders.¹⁹⁵

But, the state of access to mental health care in juvenile detention facilities is bleak.¹⁹⁶ The population of juveniles currently in detention facilities is not a small number, at almost 60,000.¹⁹⁷ Seventy percent of juveniles in detention centers have mental health diagnoses or substance abuse issues.¹⁹⁸ The country spends around \$100 million to house juveniles in detention facilities.¹⁹⁹ If the societal concerns for reform by providing adequate mental health care in juvenile detention centers is not enough, the financial concerns should be.

Mental health conditions disproportionately affect minority populations in juvenile detention centers.²⁰⁰ Young women in detention facilities are more likely to suffer from anxiety disorders and post-traumatic stress disorder,²⁰¹ and are more likely to attempt suicide than young men.²⁰²

While the government through the National Commission on Correctional Health Care (NCCHC) does provide guidelines for juvenile detention center staff to adhere to in administering mental health services, the centers often do not abide by these rules.²⁰³ Additionally, juvenile detention centers are not equipped to provide adequate treatment of mental health conditions.²⁰⁴ This can have detrimental

194. *Id.*

195. Nicole F. Roberts, *4 Things To Understand About Youth, Mental Health & Juvenile Justice In The US*, FORBES (Jan. 2, 2015), <https://www.forbes.com/sites/nicolefisher/2015/01/02/4-things-to-understand-about-youth-mental-health-juvenile-justice-in-the-us/?sh=29a8aa994e64> [https://perma.cc/VRG4-ERHA].

196. See H. COMM. ON GOV'T REFORM, *supra* note 23, at 15.

197. AM. CIV. LIBERTIES UNION, *supra* note 21.

198. Pyne, *supra* note 38.

199. See AM. PSYCH. ASS'N, *supra* note 188.

200. Two-thirds of individuals in the juvenile justice system are juveniles of color. See CHILD. DEFENSE FUND, *supra* note 44. Youth of color, LGBT+ youth, youth with disabilities, and gender-nonconforming youth are also more likely to be placed in isolation. See KERITH J. CONRON & BIANCA D. M. WILSON, UCLA SCH. OF L. WILLIAMS INST., *LGBTQ YOUTH OF COLOR IMPACTED BY THE CHILD WELFARE AND JUVENILE JUSTICE SYSTEMS: A RESEARCH AGENDA* 52 (2019), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBTQ-YOC-Social-Services-Jul-2019.pdf> [https://perma.cc/MW48-V47T].

201. See NAT'L CONF. OF STATE LEGISLATURES, *supra* note 39, at 4.

202. Nichols, Parker & Kruse, *supra* note 1.

203. See Pyne, *supra* note 38.

204. H. COMM. ON GOV'T REFORM, *supra* note 23, at 10.

effects on juveniles in their facilities including suicide,²⁰⁵ exacerbated mental health conditions, and increased recidivism.²⁰⁶ Recidivism is a costly problem,²⁰⁷ and juvenile offenders have a recidivism rate as high as eighty-four percent.²⁰⁸ Inadequate mental health care is linked to recidivism.²⁰⁹

While the government is aware of the inadequate mental health care treatment in juvenile detention centers,²¹⁰ the situation has not improved.²¹¹ This is where the legal system can assist in improving conditions for juveniles in these facilities.²¹² By filing claims either under the Eighth Amendment, alleging “cruel and unusual punishments inflicted,”²¹³ or under the Fourteenth Amendment’s Due Process Clause, alleging the right to access to mental health care treatment,²¹⁴ juvenile detention centers can be held accountable.²¹⁵

But the only way to truly hold these facilities accountable is if the courts apply the proper standard in assessing claims. While some of the courts have been applying the Deliberate Indifference Standard, which favors the facilities because the defendant can only be found liable if the individual “knows of and disregards an excessive risk to inmate health or safety,”²¹⁶ even if the defendant had knowledge of the risk, they may be free from liability if they acted “reasonably,”²¹⁷ which is a low bar as seen in *Farmer*²¹⁸ and *A.M. ex rel. J.M.K.*²¹⁹

The Professional Judgment Standard is a better choice in evaluating mental health care treatment in juvenile detention centers, as it has a lower standard of culpability than the Deliberate

205. See, e.g., *Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 329.

206. See Nichols, Parker & Kruse, *supra* note 1.

207. One study from Illinois suggests that the average cost of one adult recidivism event is over \$151,662 for the state and projects costs to the state of more than \$13 billion over the course of five years. See ILL. SENTENCING POL’Y ADVISORY COUNCIL, ILLINOIS RESULTS FIRST: THE HIGH COST OF RECIDIVISM 1 (2018), https://spac.icjia-api.cloud/uploads/Illinois_Result_First-The_High_Cost_of_Recidivism_2018-20191106T18123262.pdf [<https://perma.cc/U8JW-TSLB>].

208. See POINT PARK UNIV. ONLINE, *supra* note 20.

209. See GOTTESMAN & WILE SCHWARZ, *supra* note 74, at 1.

210. See H. COMM. ON GOV’T REFORM, *supra* note 23, at 15.

211. See, e.g., *Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 333–34 (stating that between June 2015 and May 2018, at least 45 children housed in the detention center engaged in self-harm or attempted suicide).

212. See *supra* text accompanying note 178.

213. U.S. CONST. amend. VIII.

214. See Holland & Mlyniec, *supra* note 101, at 1798.

215. See *Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 339.

216. See *Farmer*, 511 U.S. at 837.

217. See *id.* at 844.

218. See *id.* at 836.

219. See *A.M. ex rel. J.M.K. v. Luzerne Cnty. Juv. Det. Ctr.*, 372 F.3d 572, 572 (3d Cir. 2004).

Indifference Standard.²²⁰ The Professional Judgment Standard imposes liability “when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”²²¹ When applied in *Shenandoah Valley Juvenile Center Commission*, the facility was held accountable when in the course of three years, at least forty-five juveniles in their facility attempted suicide.²²² *Shenandoah Valley* demonstrates that the Professional Judgment Standard can (and should) be applied to juvenile detention centers.²²³

It is important for courts to apply a lower culpability standard to these cases as the courts have stated in *Graham* and *Miller* that the court needs to “account for the unique juvenile vulnerability to harm in confinement.”²²⁴ This would require less evidence of harm in order for protection of juveniles’ mental health while in facilities.²²⁵ While people may be concerned about the increased costs of providing better mental health care to juveniles in detention centers, the courts have limited the care to a “reasonable cost.”²²⁶

Additionally, studies have shown that by providing programs with an emphasis on intervention rather than incarceration, recidivism rates can be reduced to thirty-eight percent.²²⁷ Decreasing recidivism would save taxpayer money spent on housing juveniles in detention centers and reduce the long-term detrimental effects of mass incarceration on society.²²⁸

LYDIA G. MROWIEC*

220. See *Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 349.

221. *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982).

222. See *Shenandoah Valley Juv. Ctr. Comm’n*, 985 F.3d at 333–34.

223. See *id.* at 341 (holding that it did not matter that the facility was not a hospital or therapeutic setting).

224. See McDermott, *supra* note 18, at 751 (quoting Levick, Feierman, Messenheimer Kelley & Goldstein, *supra* note 173, at 313).

225. See *id.*

226. See *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977).

227. See POINT PARK UNIV. ONLINE, *supra* note 20, at 3–4.

228. See GOTTESMAN & WILE SCHWARZ, *supra* note 74, at 1.

* Lydia G. Mrowiec is a 2023 JD Candidate at William & Mary Law School. She obtained her Bachelor of Arts in Anthropology from Cornell University, College of Arts & Sciences in 2017. The author would like to thank her family for their unwavering support and advice throughout her academic career. Her parents have been a continual inspiration to her as evidenced in the topic of this Note, which is a marriage of their careers: a lawyer and a psychologist. They also instilled in her the importance of advocating for access to mental health. The author would like to thank her friends and her dog, Campbell. Finally, she would like to thank the *Journal* staff for making the publication of this Note a reality.