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Treatment of mentally ill juvenile offenders in the criminal justice system

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TREATMENT OF MENTALLY ILL JUVENILE OFFENDERS
IN THE CRIMINAL JUSTICE SYSTEM

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Criminal Justice

by
Robin Michelle Atlas
September 2005
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8-10-05
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This thesis is dedicated to several people, who without each of you, this never would have been possible. Thank you to my parents, Robert and Shirley Atlas, whose love and support has given me the strength to make this not only a dream, but a reality as well. You gave me life, you gave me love, and you gave me hope. Now, let me give you something in return, gratitude.

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Thank you to the Chair of my thesis, Deborah Parsons. I could never have done this without you. Thank you for taking so much of your own time to help me through this. Thank you to my other committee members, Dale Sechrest and Frances Coles, for working with me on my thesis and helping me achieve my goal.
Mental illness among juvenile offenders is a serious problem. Mentally ill juveniles who are incarcerated in correctional facilities receive minimal or no treatment services. It is a growing problem with few solutions. This thesis examines mentally ill juvenile offenders in the criminal justice system.

Ten subjects in the criminal justice profession were interviewed to obtain a better perspective of how mentally ill juvenile offenders are treated by the criminal justice system. Although there are limitations, this research determines that mentally ill juvenile offenders receive inadequate treatment. Factors that impacted the poor conditions of correctional facilities included mentally ill juveniles being housed in deplorable conditions, suffering from abuse at the hands of correctional officers, and having little or no time with a psychologist or a psychiatrist. It is also determined that juvenile correctional officers, as well as others in the criminal justice system, are not trained properly to deal with mentally ill juveniles. Furthermore, the laws dealing with mentally ill juvenile offenders are found to be insufficient at a minimum. The majority of the
participants could not recall any laws specific to mentally ill juveniles.

Future research should attempt to include quantitative research and consist of a larger sample size to allow for more detailed results. Future research should also look at other aspects of mental health, including staff employed at mental health facilities, school psychologists, and social workers.
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CHAPTER ONE

INTRODUCTION

Many juveniles who commit crimes are in need of mental health treatment and intervention. In some cases, they are incarcerated in correctional facilities without the benefit of treatment. Some research indicates that the number of mentally ill juveniles sitting in correctional facilities is astounding. In fact, the Treatment Advocacy Center reports that there are more mentally ill individuals in correctional facilities than there are in mental health facilities (Faust, 2003).

The extent of the problem regarding the incarceration of mentally ill juveniles has not been fully explored. Little research has been done in the area of mentally ill offenders in general, and of mentally ill juvenile offenders in particular. The primary purpose of this thesis is to explore the issue of mental illness among juvenile offenders and to determine if the problem not only warrants public concern but also legislative, legal, and policy changes. The goals of the present research are to examine the extent of the problem and to identify contributory factors.
While the first objective of this thesis is to explore the extent of the problem, the second objective is to discover why incarceration and not treatment is the preferred response. Upon preliminary examination of this problem, it appears that several factors are responsible. The factors that impact the handling of mentally ill juvenile offenders in the criminal justice system are the focus of this research.

One factor impacting the disposition of offenders is the debate over punishment versus rehabilitative models of correctional philosophy. Currently, the public's low tolerance of offenders and criminal behavior, including that of juveniles, reflects a punitive perspective. The desire to punish rather than treat criminal offenders is apparent in the support of tough legislation, such as mandatory-minimum sentencing and the three-strikes law. High jail and prison populations, overcrowded conditions, increases in length of time served in custody, and increases in the incarceration of women and juveniles are evidence of a punitive society, one that builds more prisons than schools or treatment facilities (Aufderheide & Brown, 2005). This explains that while state mental facilities continue to close, an abundance of new prisons
continue to open, as demonstrated by the more than 400 new prisons that have opened in the past decade (Serafini, 2002).

On average, 10 million adults are incarcerated in local jails every year (Serafini, 2002). Although not as serious, this is compared to over 100,000 juveniles detained in both public and private facilities in 1999 (Sickmund & Wan, 2002). Little attention is paid to the individual offender and to any hope for rehabilitation, thus mental health issues seldom are addressed when sentencing decisions are made.

A second factor impacting the incarceration of mentally ill juveniles is the lack of funding for treatment facilities. Earlier research revealed little or no effectiveness of rehabilitation programs and a high recidivism rate for offenders contributed to the disillusion of treatment as the preferred method to handle offenders. This also resulted in a move away from funding treatment programs. Because public support for a tough justice system has resulted in increased spending on punitive measures and restricted funding for treatment, few treatment-oriented programs are able to continue to operate. Certainly one of the hardest hit in terms of
decreased spending and elimination of programs is on treatment for the mentally ill (Serafini, 2002).

Following the change of philosophy from rehabilitation to punishment, mentally ill persons, including juveniles, no longer have easy and available access to treatment such as counseling and needed psychotropic drugs (Serafini, 2002). Often, mentally ill persons come to the attention of police when they act in a bizarre fashion (Gannon, 2005). Even when their behavior is not illegal, the police may arrest them by using vagrancy, littering, or loitering laws to move them away from citizens who demand that the police "do something!" With nowhere to take such individuals, more often than not, the mentally ill person will end up in jail. In the case of mentally ill juveniles, similar circumstances prevail. A mentally ill juvenile who is refused treatment may exhibit unacceptable behavior and become incarcerated in a correctional facility (Faust, 2003).

Behavior is at the center of another issue in the problematic handling of juveniles in the criminal justice system. If, in fact, juvenile misbehavior cannot be officially labeled as "illegal," the problem arises in defining the behavior that separates mentally ill from non-
mentally ill juvenile offenders. A growing body of literature surrounds the issue of behavioral problems of juveniles and may have the answer, as Conduct Disorder and Oppositional Defiant Disorder (ODD) define the behavioral problems of certain disturbed juveniles (Horne & Sayger, 1990).

ODD is defined as a pattern of negative and hostile behavior in which the child has difficulty controlling his or her temper, angers easily, tends to argue with adults, and is easily irritated. Juveniles suffering from ODD defy authority, intentionally annoy others, and fail to accept responsibility for their actions. The behavioral symptoms of this disorder occur primarily in the home (Horne & Sayger, 1990).

Conduct Disorder includes more disruptive behavioral problems. These problems tend to be more serious than in ODD, and physical aggression is a common tendency. While the ODD behaviors tend to occur in the home, Conduct Disorder behaviors can occur anywhere, from home to school to the community. This type of behavior tends to include cruelty to people or animals and criminal behavior such as vandalism or stealing. As the child ages, violence becomes a prevalent part of this disorder and can lead to rape,
assault, and in extreme cases, homicide (Horne & Sayger, 1990).

Another type of behavioral disorder is Attention Deficit Hyperactive Disorder (ADHD). ADHD is difficulty maintaining attention or hyperactive behavior (Diagnostic and Statistical Manual of Mental Disorders, 2000). A concern of ADHD is the over-diagnosis of this disorder. Over-diagnosis of ADHD, for example, is termed the epidemic of the 90s. A number of parents were informed that their child had ADHD, which caused parents to seek help. An issue of concern was whether drugs should be used to control the "hyperactive" and "disruptive" behavior. When properly medicated for the appropriate disorder there are substantial benefits. The medications used to treat ADHD have been used for over 40 years and well over 1,000 investigations regarding these medications have been completed. While these medications are not without negative effects, the benefits of medication seem to outweigh the negative effects for most children with ADHD (Haber, 2003).

Another concern of this disorder is the mis-diagnosis of ADHD. A number of children are being mis-diagnosed and treated unnecessarily. This is due to ADHD having similar
symptoms to other disorders, which causes children with symptoms similar to ADHD to be treated for this disorder (Haber, 2003).

This thesis, in part, attempts to uncover the problem with diagnosis of mental illness. Children may be mis-diagnosed with a mental illness or with "behavior problems" when a lack of professional assessment is available. To accurately diagnose a mental disorder there are necessary questions to be asked including past history, symptoms, medical history, and family history (Gorman, 1996). Early mis-diagnosis may create its own perpetuation of the problem, resulting in the labeling of the juvenile as a criminal offender. Labeling theory, a classical criminological theory, argues that juveniles may be labeled as deviant because of an early indiscretion and through labeling, they may continue to act out in a self-fulfilling manner (Sullivan & Wilson, 1995).

Nonetheless, diagnosis of a mental illness is a complicated process, partly due to the extensive number of different disorders. Mental illness may include Schizophrenia, Anxiety Disorders, and depression (Gorman, 1996). Schizophrenia lasts at least six months and generally includes hallucinations, delusions, grossly
disorganized or catatonic behavior, or disorganized speech. Those who suffer from Schizophrenia are generally less sociable, less educated, and have more difficulty remaining employed. The symptoms can be mild or severe depending on the person (Diagnostic and Statistical Manual of Mental Disorders, 2000). Anxiety Disorder is characterized by at least six months of consistent and extreme worrying and nervousness and includes Panic Attacks, Obsessive Compulsive Disorder (OCD), and Posttraumatic Stress Disorder. Depression targets at least 1 in 10 people and is viewed as a serious illness. Without treatment, depression can lead to suicide, and therefore people suffering from depression should be considered at-risk (Gorman, 1996).

Mentally ill people may be vulnerable to a number of serious consequences, often while awaiting treatment in correctional facilities. These consequences can include abuse, suicide, criminal behavior, violence, self-mutilation, as well as, minor behavioral problems that are not as serious. California is just one of the states where abuse and mistreatment exists in juvenile correctional facilities. In one facility, it was discovered that the mentally ill were not properly treated; that facility
punished the children by locking them in small cages (Sacramento Bee, 2004). A facility in Maryland employed staff that physically attacked the children detained there, despite numerous prior citations for violence (Cannon & Beiser, 2004). Abuse and mistreatment can lead to suicide if nothing is done (Faust, 2003).

Lack of diagnosis through professional means and entry into a system that was created to house society’s criminals, exposes mentally ill juveniles to atrocities they are incapable of handling. This creates the criminal behavior the criminal justice system is supposed to prevent or deter (Cannon & Beiser, 2004).

The criminal justice system was created to handle criminals. Officials who work in the system, such as police and correctional officers, are unlikely to be prepared or trained to deal with mentally ill people because they are rarely provided with specific training on mental illness. Their immediate response is to control behavior through the means they were trained to use, like restraint methods. Inadequate training of criminal justice officials may result in abuse of individuals in their care. While the actions taken by the officials may not be intentionally abusive, to a mentally ill juvenile the
response may be traumatic. Another contributory factor, therefore, results in the mishandling of mentally ill juveniles in a system not designed to deal effectively with their disorders. In the long run, society benefits little from the continued non-treatment, and sometimes mistreatment of mentally ill juvenile offenders (Cannon & Beiser, 2004).

This thesis covers many aspects of mentally ill juveniles and mentally ill juvenile offenders. Mental illness will be defined and various types of mental illness will be explored. Incarcerated mentally ill juveniles will be compared to incarcerated mentally ill adults. Various aspects of treatment both inside and outside of correctional facilities will be discussed. Abuse and suicide within correctional facilities will also be examined. Finally, the cost of treatment and the lack of funding will be explored, as well several alternatives to incarceration.
CHAPTER TWO

LITERATURE REVIEW

Concept of Mental Illness

Mental illness is a serious issue in the United States. It includes a number of disorders, such as Schizophrenia, Anxiety Disorder, and depression. It can also include substance and alcohol related disorders. It is estimated that over 40 million Americans suffer from mental disorders. One in five Americans suffer from a mental condition, while one in four Americans suffer from an alcohol or drug addiction (Serafini, 2002). Approximately 30 to 35% of mentally ill Americans become involved in the criminal justice system at some point in their lives (American Psychiatric Association, as cited in Aufderheide & Brown, 2005).

Schizophrenia is a disorder, which lasts for six months or longer and includes at least one month of two or more of the following symptoms: hallucinations, delusions, grossly disorganized or catatonic behavior, disorganized speech, or negative symptoms including emotional and cognitive dysfunctions. Those who suffer from Schizophrenia are less sociable, tend to be less educated,
and have more difficulty remaining employed. The symptoms can be mild or severe depending on the person. Generally, Schizophrenia occurs between late adolescence and the mid-30s. Although rare in children under 12, there have been some reported cases, however, diagnosis is more difficult at such an early age (Diagnostic and Statistical Manual of Mental Disorders, 2000).

Anxiety Disorder is defined as six months or more of consistent and extreme worrying and nervousness. Included in this disorder are Panic Attacks, Obsessive Compulsive Disorder (OCD), and Posttraumatic Stress Disorder. A Panic Attack is a sudden feeling of fear, terror, or apprehension, which can include physical symptoms such as shortness of breath, pain in the chest or other discomfort, or a choking sensation. OCD is an obsession brought on by distress or anxiety, which helps to relieve the anxiety. Posttraumatic stress disorder occurs following a traumatic event and is characterized by the person mentally re-experiencing the same traumatic event repeatedly throughout his or her life (Diagnostic and Statistical Manual of Mental Disorders, 2000).

Depression targets at least 1 in 10 people and is viewed as a serious illness. Without treatment, depression
can lead to suicide, and therefore people suffering from depression should be considered at-risk (Gorman, 1996).

Mental illness differs from mental retardation, although, like mental retardation, it is a malfunction of the brain (Bayes, 2004). Mental illness disorders make it difficult to think, feel, relate, and cope with everyday life. They can affect persons regardless of age or heritage ("Mental Illness Defined," no date). A person suffering from a mental illness is viewed as having a disability. These people are separated from society and viewed differently from what society has deemed "normal" (Hart, as cited in Investigating Difference, 2000).

Mentally Ill Juveniles

Juveniles who are mentally ill face a variety of challenges on a regular basis and are forced to overcome these obstacles with little or no help from society. For decades, those who suffer from a mental illness have often been viewed as unimportant, are frequently overlooked by society, and are rarely given the chance to prove that they are people too. These juveniles crave to be "normal" and fit in with the rest of society. Instead they feel that they are shunned from society and have no part in it, making it difficult for them to accept their mental illness
due to the lack of support (Hart, as cited in Investigating Difference, 2000).

Mentally ill children who lack a criminal record rarely receive mental health treatment from the criminal justice system and are forced to endure the hardships of correctional facilities. However, mentally ill juvenile offenders, those who have committed a crime, especially a violent one, are in need of not only mental health treatment, but also punishment (Ferrell, as cited in Investigating Difference, 2000). Although it is a common assumption for juveniles who have a mental illness to be deemed victims, some are actually offenders. While non-mentally ill juveniles tend to commit more conservative crimes, like shoplifting, juveniles suffering from a mental disorder are more likely to commit violent crimes since they tend to behave aggressively and violently if their illness is left untreated (Hart, as cited in Investigating Difference, 2000).

Treating a mentally ill juvenile offender is beneficial to both the juvenile and to society. Treatment alone, however, does not solve society’s agenda to punish those who have committed a crime in order to discourage them from committing future crimes. It is important,
therefore, to have a balance between punishment and rehabilitation (Ferrell, as cited in Investigating Difference, 2000). Today, however, society tends to have a more stringent penal system and focuses more on punishment. As a result, a significant number of states for example, have created laws allowing juveniles to be tried as adults (Cannon & Beiser, 2004).

Mentally ill offenders often pose several problems for correctional facilities and the staff employed there. Specific services, increased staff, and distinctive regulations are necessary to accommodate these offenders. However, mentally ill offenders are not always afforded the opportunity of these services because society, and on occasion the courts, often assume that mentally ill offenders are housed in specialized units where they are provided adequate treatment. Although there are often specialized units available, mentally ill offenders are generally housed with the general population (Norton, 2005).

Incarceration, the Preferred Approach

Some questions remain regarding the appropriateness of incarcerating mentally ill juveniles (Clear, as cited in
Lurigio, 1996). As treatment becomes less available, incarceration of mentally ill juveniles becomes the more preferred approach despite their criminal history, or lack thereof (Cannon & Beiser, 2004; Weedon, 2003; Werner, 2004). In July of 2004, a congressional report revealed that detention centers in 33 states hold mentally ill juveniles who have not committed a crime (Brogan, 2004; Cannon & Beiser, 2004; Werner, 2004). According to Dr. Fred Osher, the Director of the Center for Behavioral Health at the University of Maryland, “There’s a whole host of folks who land in the criminal justice system because of their behavioral disorders” (Kanapaux, as cited in Aufderheide & Brown, 2005, p.31). On average, mentally ill juveniles are held in detention centers for more than 23 days, as opposed to 17 days for all other detainees (Werner, 2004). On a daily basis, approximately 2,000 juveniles are incarcerated due to a lack of mental health services. According to Ernestine Gray, a juvenile court judge in New Orleans,

It is a terrible miscarriage of justice to detain or incarcerate children in order that they might be able to have a chance of getting any mental health services. Our detention facilities should
not be used as substitute hospitals. (Brogan, 2004, p. A10+)

It is unknown what the exact reasoning is behind incarcerating mentally ill juveniles. There are however, two possible explanations. First, child welfare services often advocate for transferring custody of the mentally ill child from the parents to the state; as a result, incarceration becomes the preferred approach. Second, schools lack the capability to deal with mentally ill juveniles; their disruptive behavior, whether minor or serious, eventually leads to involvement with the criminal justice system (Ginsburg & Demeranville, 1999).

A number of detention centers are used to house mentally ill juveniles and produce undesirable results because these centers are ill equipped to handle the needs of the mentally ill. This has become a serious problem with no solution in sight. In 2003, a House committee in Washington reported that two-thirds of juvenile detention centers housed juveniles awaiting mental health treatment. Thus, detention centers have become holding areas for mentally ill juveniles. Thousands of children awaiting treatment are detained in correctional facilities until treatment is made available (Werner, 2004; Brogan, 2004).
Juvenile Correctional Facilities

The United States has one of the highest incarceration rates in the world. While only 8% of the world's population lives in the United States, 25% of the world's inmates are housed in correctional facilities throughout the country (Aufderheide & Brown, 2005). Juvenile correctional facilities were originally created to help juveniles improve their behavior (Cannon & Beiser, 2004). However, these facilities were not tailored to the needs of the wide spectrum of children housed there. There was no distinction made between juvenile delinquents and juveniles who suffered from abuse or neglect only (Kinnear, 1995). Also, there was no type of aftercare; once they had been rehabilitated, or turned 21 years old they were released back into society (Cannon & Beiser, 2004).

In 1932, the first correctional facility was opened in Ohio with the philosophy that children had different needs than adults. Within the facility, children were separated by their individual needs and the purpose for their referral. This facility introduced the concept that juvenile offenders should be separated from juveniles with only special needs (Kinnear, 1995). However, this view changed considerably when violent crime among juveniles
increased toward the end of the twentieth century (Cannon & Beiser, 2004).

In 2002, there were 191,579 juvenile arrests reported. Of those arrests, 50,365 were felonies, 109,775 were misdemeanors, and 31,439 were status offenses. Felonies and misdemeanors are delinquent acts, which are considered crimes regardless of age. Status offenses are only illegal due to the juveniles' age; these offenses include running away and truancy (California Department of Justice, 2002).

Of the total number of arrests, only a small number of juveniles were referred to counseling, while a large number were referred to probation. Thirty three thousand, eight hundred juveniles were detained in both secure and non-secure facilities, while 65,779 of the juveniles arrested were never detained. Of those referred, 113,852 were referred by law enforcement agencies while only 1,202 were referred by schools (California Department of Justice, 2002). Due to the increase in arrests and severity in the types of crimes committed, society changed its view and became less concerned with rehabilitating juveniles, and focused more on punishing them (Cannon & Beiser, 2004).

The main purpose of correctional facilities is to rehabilitate offenders and prepare them to be released back
into society. Although mentally ill offenders are more difficult to deal with because they require more supervision, correctional facilities still have a responsibility to take care of and provide treatment to them. Unfortunately, the criminal justice system is too often used as a “dumping ground” for these offenders due to lack of available mental health treatment (Gondles, 2005). On any given night, approximately 2,000 juveniles waiting for mental health services are incarcerated in correctional facilities across the nation. These children have done nothing criminal and have only been diagnosed with a mental illness (Jansen, 2004).

Treating people prior to entry into the criminal justice system would relieve the burden that correctional facilities endure on a regular basis (Faust, 2003). For many mentally ill offenders, incarceration is their first opportunity for mental health treatment, or any type of health care for that matter. In addition, incarceration may be the first time they are diagnosed with a mental illness (Norton, 2005).

It is reported that there are almost 300,000 people suffering from a mental illness in correctional facilities, while there are only approximately 60,000 mentally ill
people in mental health facilities. The issue of placing the mentally ill in correctional facilities rather than mental health facilities is growing at a significant rate and will continue to increase if a viable solution is not explored (Faust, 2003).

Since many mentally ill juveniles are not diagnosed or offered treatment until they come in contact with law enforcement, it is unlikely that they would have received treatment prior to them breaking the law. A great concern is that many children’s psychiatric hospitals are closing, leaving few options for housing mentally ill juveniles. Both adult and juvenile correctional facilities seem to be becoming the default psychiatric hospitals of the future. Unfortunately, without adequate mental health services, juvenile correctional facilities seem to have a worse effect on these children than if they never received any intervention (Cannon & Beiser, 2004).

According to a congressional report released in July of 2004, two-thirds of juvenile correctional facilities are holding juveniles who have been diagnosed with a mental illness. Two-thirds of those juveniles have had physical altercations with other juveniles or have attempted suicide (Cannon & Beiser, 2004).
A number of challenges exist, as approximately 60% of the juveniles incarcerated in correctional facilities suffer from a mental illness or substance abuse. Instead of receiving mental health treatment, these juveniles leave the facility having criminal experience. According to Ralph Thomas, who monitors juvenile facilities in Maryland, "Many of these kids come out worse for their experience in these facilities. They're more likely to prey on society" (Cannon & Beiser, 2004 pg. 32).

The main focus of the correctional system is to punish offenders. As a result, mentally ill juveniles who are housed in correctional facilities are punished rather than treated. Not only is this ineffective, it is also a poor attempt to solve the problem of mental illness. Detaining the mentally ill fails to fix the problem of mental illness due to the lack of mental health treatment they receive in detention, which in turn fails society because these juveniles leave the correctional facilities in worse shape than when they started. Instead of attempting to correct the problem of mental illness, the staff in correctional facilities are attempting to "band-aid" the situation by locking away the mentally ill and hoping the problem will disappear (Clear, as cited in Lurigio, 1996).
Spokane County Juvenile Detention Center in Washington, houses the mentally ill and is referred to as a short-term mental hospital. The number of suicidal and self-mutilating juveniles in the facility has increased significantly. Similarly, the number of staff requesting mental health intervention for the juveniles housed there has also increased at a rapid rate. Juveniles suffering from a mental illness are subjected to a facility that cannot provide adequate mental health treatment and only serves as a place to house them (Martin, 2002).

Many detention centers lack a mental health program and instead keep mentally ill juveniles in seclusion for hours straight. This approach has proven to be ineffective, as the mentally ill juveniles continue to return to the correctional facilities in an endless cycle with mental health treatment remaining an unattainable goal (Martin, 2002).

A significant number of detained juveniles are thought to be mentally ill. Forty to 70% of juveniles in detention centers have a diagnosable mental illness (Martin, 2002). Substance abuse problems are common among half of those juveniles. Approximately 11% of these juveniles are said to be severely emotionally disturbed. Eighty percent of
the juveniles that come in contact with the juvenile justice system have some type of mental illness (Biggins & Oss, 2003). The Office of Juvenile Justice and Delinquency Prevention reported that a substantial number of mentally ill juveniles come in contact with the juvenile justice system on a yearly basis. At least 20% of them suffer from severe mental disorders (Weedon, 2003). This has become an ongoing problem with a lack of solutions. At both the county and state levels, mental health services that adequately treat mentally ill juveniles are not readily available. According to Lisa Boesky, a clinical psychologist who trains correctional staff, "Jails and detention centers have become the mental health hospitals" (Martin, 2002, p. A1+).

The "quick fix" solution of incarcerating mentally ill juveniles has been implemented since the early 1990s. This trend overcrowds detention centers and has proven to be ineffective in treating juveniles who suffer from a mental illness. Instead of solving the problem, juvenile detention centers make matters worse and are referred to as a "dumping ground" for mentally ill juveniles (Martin, 2002).
Correctional facilities are not adequate places to house those suffering from a mental illness and many of these facilities lack the resources to provide sufficient services for the mentally ill (Faust, 2003). Unfortunately, the United States seems more concerned with funding correctional facilities than mental health facilities and there seems to be little concern for children suffering from a mental illness (Jansen, 2004).

Correctional facilities do not provide adequate treatment for the mentally ill (Serafini, 2002). They are intended for offenders and are not properly equipped or adequately designed to house mentally ill juveniles (Clear, as cited in Lurigio, 1996). In addition, even those mentally ill juveniles who have not committed crimes are punished and forced to live in deplorable conditions. According to Stephen Inglely, the executive director of the American Jail Association, when a person is brought to a correctional facility,

Sometimes services are available, sometimes not. Oftentimes, the resources aren’t there.... You can’t be the correctional officer, the mental-health expert, the counselor, the legal expert.
It doesn't work, and it's not good for anybody.

(Serafini, 2002, pg. 1130)

Mental health services vary among correctional facilities. Depending on the facility, some inmates can receive sufficient mental health treatment, however, it is rare. Some correctional facilities have full time psychiatric services, while other facilities lack any services (Serafini, 2002). At some facilities the staff psychiatrist is rarely on site, while at others, juveniles with severe mental disorders are never referred to a psychiatrist. At Jetson Correction Center in Louisiana, psychiatric evaluations do not extend past eight minutes (Ginsburg & Demeranville, 1999).

Although the mental health treatment received at correctional facilities is generally inadequate and not worth receiving, for some mentally ill juveniles, it is the only treatment they are able to obtain. Unfortunately, when they are released into society they are back to where they started. According to Serafini (2002), it is a gamble to try to guess what facilities are adequate and what facilities leave the children worse off than before they entered detention.
Prisons

Despite the high population of mentally ill juveniles in correctional facilities, juvenile prisons, where the more serious juvenile offenders are detained, also deal with mentally ill juveniles on a regular basis. In 2000, a survey conducted by the Juvenile Rehabilitation Administration discovered that of the 1,100 juveniles incarcerated in juvenile prisons, 40% of them were mentally ill. In Idaho’s juvenile prisons, of the 450 juveniles incarcerated, 22% of them have a serious mental illness (Martin, 2002). While juveniles continue to be housed in prisons, the adult prisons continue to grow in order to accommodate the large increase in the population of more than 60,000 people each year. Currently, the prisons in the United States house over 2 million people (Aufderheide & Brown, 2005).

Abuse in Correctional Facilities and Prisons

When mentally ill juveniles are held in correctional facilities without mental health treatment, lasting negative effects can occur. When mental health treatment is not provided quickly to incarcerated juveniles, these juveniles can resort to other means, such as suicide. At Preston Youth Correctional Facility in Sacramento, two
mentally ill juveniles committed suicide in January 2004. What followed was an investigation that revealed violence and abuse throughout California's juvenile correctional facilities. The investigation exposed that mentally ill juveniles were not properly medicated or provided with essential treatment. As a form of punishment, they were locked in small wire mesh cages. It was discovered that California is the only state to use this form of punishment. Juveniles were detained in filthy cells for almost 24 hours a day, sometimes for months at a time. As a result of the horrendous conditions, even non-mentally ill juveniles could feel the effects of that horrific type of punishment (Sacramento Bee, 2004).

Although California has a serious problem concerning abuse among mentally ill juveniles, other states are not above reproach. The Cheltenham Youth Facility in Maryland received a number of citations for extreme violence. In an attempt to quiet the mentally ill juveniles detained there, the staff at this facility attacked the children in the middle of the night, regardless of their age. On one occasion, the staff choked a 12 or 13-year-old boy because he was "acting hyper". The Hickey School in Baltimore is no better. In the past two years 70 abuse and neglect
investigations have been launched. A quarter of them were found to be true and 30% of them were unfounded (Cannon & Beiser, 2004).

All over the United States, mentally ill juveniles are being incarcerated in correctional facilities. Whether it is due to lack of funding, lack of space, or lack of patience, these children are forced to live and suffer in horrendous conditions. Children who are mentally ill, delinquent, or both, are abused and mistreated on a regular basis at these facilities (Cannon & Beiser, 2004).

At Cedar Springs, a locked facility in Colorado, mentally ill juveniles are chained, and feces cover the bathroom walls (Ginsburg & Demeranville, 1999). The Heman G. Stark Youth Correctional Facility in Chino, California sends children in need of discipline to a place known as “the rock.” The cells are dim and dreary, and the showers consistently leak. This particular facility has a mental health unit. There, the children spend their time yelling and cursing, or pacing back and forth in their cells. Stark is known for being the toughest prison in the California Youth Authority system. In 2003, almost 300 attacks between juveniles occurred there, which doubled the number of attacks in 2002. Even the most hardened juvenile
delinquents sent there for murder do not feel safe there. For example, German Carranza, now 23, was sent to Stark at age 17 for a gang-related murder; he stated, "I don’t feel safe here. But you get so used to it you don’t feel fear. You’re just alert all the time" (Cannon & Beiser, 2004 pg. 30).

In Connecticut, mentally ill juveniles were treated poorly and were handcuffed to their beds. In a residential treatment facility in Pennsylvania a mentally ill boy died while he was in restraints (Ginsburg & Demeranville, 1999). In the Columbia Training School, a correctional facility in Mississippi, children were hogtied, shackled to a pole and then left on public display for long periods of time. Some of the female juveniles were required to eat their own vomit (Cannon & Beiser, 2004).

Suicide in Correctional Facilities

If left untreated, mental illness can lead to suicide, which is a definite concern among children diagnosed with a mental illness. The National Institute of Mental Health reports that more than 70% of people who commit suicide suffer from a mental illness. However, less attention is paid to those mentally ill juveniles who are incarcerated despite the fact that suicide is becoming more prevalent.
among these juveniles. Additional risk factors that can lead to suicide are the occurrence of mistreatment and abuse experienced by mentally ill juveniles who are incarcerated (Faust, 2003).

Mental health treatment is meant to prevent self-harm. Without adequate treatment, suicide, attempted suicide, and deteriorating mental capacity are not uncommon occurrences in correctional facilities (Jansen, 2004). In a Louisiana juvenile prison, a boy attempted suicide in front of a guard, while the guard watched, rather than attempting to stop the boy (Ginsburg & Demeranville, 1999). In Maine, an 18-year-old male adolescent housed in the state’s most restrictive prison hung himself while waiting for a hospital bed. A 13-year-old boy diagnosed with depression spent his first 152 days of detention in isolation, which increased his depression, aggression, and self-mutilation (Jansen, 2004). The Columbia Training School in Mississippi, locked suicidal girls, who were stripped of their clothing, in a pitch-black room that contained a drain in the floor for a toilet. A number of correctional facilities in different states have reported disproportionately high rates of suicides (Cannon & Beiser, 2004).
Adult Correctional Facilities

Mental illness among adults is also a serious problem. With less mental institutions available, jails are becoming the place to house the mentally ill. In fact, Los Angeles County Jail, Rikers Island Jail in New York City, and Cook County Jail in Chicago have become three of the largest "de facto psychiatric facilities" for adults. They have become repositories for the mentally ill. The Miami-Dade County Jail has twice the number of mentally ill than the South Florida Evaluation and Treatment Center. All over the country, the county jails are housing significantly more people who have a mental illness than the psychiatric facilities (Faust, 2003).

According to the National Alliance for the Mentally Ill, there are three times more mentally ill Americans in prisons than in mental health facilities (National Alliance for the Mentally Ill, as cited in Aufderheide & Brown, 2005). In addition, jails are spending a significant amount of money in an attempt to administer mental health treatment, as shown by Los Angeles County Jail, which spends $10 million a year to pay for psychiatric medication (Faust, 2003).
Treatment Within Correctional Facilities

While mentally ill offenders compose a small portion of the entire correctional system, they demand the most attention from staff. They are in need of mental health treatment programs from the beginning and throughout the duration of their incarceration. Mentally ill offenders should be monitored throughout their stay in order to prevent relapse and to ensure compliance with the treatment. Although medication is a necessary part of treatment, an effective program consists of more than just a "quick fix" to the problem of mental illness. Adequate treatment includes substance abuse treatment, health care, employment training and skills, education, and allowing the offender to be held accountable for his actions, including appropriate punishment (Norton, 2005).

Many mentally ill juveniles could function normally in society if provided with the proper treatment. However, after being incarcerated without adequate treatment and after being exposed to abuse and mistreatment, they are released into a society in which they cannot function properly. Often, they are released in worse shape than before they were offered treatment because many of them are needlessly sent to facilities where treatment is scarce and
abuse is common (Cannon & Beiser, 2004). Regardless of the reason behind incarcerating mentally ill juveniles, juvenile detention centers offer few effective rehabilitative programs ("Justice for Juveniles," 1999).

Mental health treatment is less important than punishment, thus, psychiatric hospitals are being replaced by correctional facilities. It seems that treating those who have a mental illness is no longer a priority or even a concern among society (Faust, 2003). Treating the problem before it gets out of control seems to be the ideal solution. Treatment, however, seems to be out of reach for mentally ill juveniles (Faust, 2003). The majority of mentally ill juvenile offenders have committed crimes due to a lack of treatment (Bayes, 2004).

Treating mental illness is difficult in a hospital setting; however, treating mental illness in a detention setting is nearly impossible due to the lack of trained staff and the lack of resources. In the past, juveniles were not questioned regarding their mental health history; this led to failure to diagnose mentally ill juveniles or treat them appropriately. Assuming that the mental illness has been diagnosed, the diagnosis is pointless if the
mental hospitals refuse to accept those juveniles who need mental health treatment (Martin, 2002).

Generally, transfers from detention centers to mental hospitals occur on a monthly basis, and usually only one juvenile is transferred at a time (Martin, 2002). Even if transfers could occur more frequently, approximately 60% of the time juveniles are not accepted by the mental health facilities (Serafini, 2002). In addition, some facilities have waiting lists that extend beyond three months. It is a frustrating process with feeble results (Martin, 2002).

Joanne Mudd, a Virginia social worker stated, “the community is band-aiding the situation and is hoping there’s nothing too serious” (Serafini, 2002, pg 1128).

Treatment facilities have lengthy waiting lists and there are no guarantees that the mentally ill juveniles awaiting treatment will be admitted (Martin, 2002). In 1998, Virginia had 10,000 people on a waiting list for mental health services. Those who were not an imminent danger to others or themselves were moved to the bottom of the waiting list; even those not in immediate danger became at-risk when waiting for admission because they did not receive medication during that time-frame (Serafini, 2002).
Many mental health facilities are overcrowded and lack the necessary resources to provide treatment. Even when the facilities are not overbooked, a lack of funds makes it difficult to treat the mentally ill juveniles (Serafini, 2002). Additionally, the mental hospitals that are not overcrowded and are able to provide treatment are reluctant to accept mentally ill juveniles detained in detention centers due to safety concerns. The staff working in mental hospitals would prefer that the mentally ill juveniles in detention centers remain in custody, which has an impact on the number of mentally ill juveniles who are accepted by mental health facilities. Ultimately, that leads to correctional facilities to provide treatment for mentally ill juveniles (Martin, 2002).

Although mentally ill juveniles are better off in mental health facilities than in correctional facilities, once they receive treatment and become stabilized, they can be released back into society assuming there are community resources available. There are a number of mentally ill juveniles stranded in psychiatric facilities despite their status as ready to be released. With the lack of community services to help them upon their release, their progress in psychiatric facilities is futile. It has been predicted
that approximately 25% of mentally ill patients could be released back into the community if there were adequate resources available. Regrettably, they are not released and instead eventually deteriorate in the facility (Serafini, 2002).

While available psychiatric beds are almost nonexistent, prison beds are rapidly increasing. The world is changing by building more prisons while at the same time shutting down mental health facilities. It is not coincidental that in the past decade 40 state mental health facilities have shut down while over 400 new prisons have opened. According to the Sentencing Project, in 1955, more than 500,000 patients crowded the state mental hospitals. Today, the hospitals house less than 100,000 patients. When hospitals close, they turn away a number of potential patients leaving mentally ill people without treatment and with no other place to go. This has resulted in correctional facilities becoming the only place for mentally ill juveniles to receive treatment, which poses a serious problem since correctional facilities do not provide adequate treatment (Serafini, 2002).

A constant battle exists between the hospitals and the communities. A patient receives treatment until he or she
is stabilized, which is generally within one week. The patient is then released into the community where he or she is expected to seek out continued treatment. However, mental health services within the communities are overcrowded and place recently released patients on a waiting list where they may wait for months without medication (Serafini, 2002).

**Medication**

With the help of medication, mentally ill juveniles can lead productive lives that require little supervision from psychiatric facilities and no supervision from correctional facilities (Serafini, 2002). While medication is a necessary part of treating the mentally ill, it does not "cure" mental illness. Medication allows stability among the mentally ill and provides them with the means to cope functionally in society. According to Thomas White, a previous administrator of psychology services with the Federal Bureau of Prisons,

Medication clearly has a place in many treatment regimens, but it is rarely sufficient in and of itself to help inmates make a permanent, long-term adjustment to their surroundings.

(Aufderheide & Brown, 2005, p. 32)
Although medication is an important aspect of mental health treatment, taking medication also presents some negative consequences. For example, there exists a risk of overmedicating and becoming addicted to certain medications. According to Dr. Mary Ann Block (1997), medication alone is the most prevalent type of treatment for ADHD. Suggestions for past treatment include combining medication with educational services and behavior modification. However, studies have reported that pediatricians in general prescribe medication without the benefit of the other types of treatment. While approximately 80 to 85% of juveniles who have been diagnosed with ADHD receive drugs to treat their illness, only about half of those juveniles also receive the benefits of behavior modification and educational services in addition to medication (Barkley, as cited in Block, 1997).

There are several other medications also used to treat this behavior disorder such as Paxil, Prozac, and Clonidine, however, Ritalin remains the number one drug prescribed. The Drug Enforcement Agency (DEA) monitors the number of Ritalin pills manufactured by drug companies each year. In 1993, Ritalin was prescribed so frequently that
the DEA allowance was exhausted, which led to a shortage of Ritalin pills. The shortage reeked havoc on the parents whose children were taking Ritalin as their only form of treatment (Block, 1997).

As with many drugs, Ritalin has negative effects. First, it only treats the symptoms and does not address or attempt to fix what causes the symptoms. It suppresses the symptoms while the child is taking the medication, however, when the child stops taking the medication the symptoms return. According to Dr. Mary Ann Block (1997), “Drugs are a short-term answer to treating long-term symptoms, and they carry the potential of serious side-effects” (p. 28). Second, it is highly addictive. Although Ritalin has been used for years to treat behavioral disorders, it has been compared to other addictive drugs such as cocaine and methamphetamine. Nevertheless, it is a controlled substance, meaning that the government maintains a record of Ritalin prescriptions. ABC’s 20/20 show from October 27, 1995 exposed the misuse of Ritalin, “citing incidents in which children are snorting Ritalin, teachers and pharmacists are stealing it, and parents are selling it” (Block, 1997, p. 30). It appears that Ritalin has more negative effects when it is used by itself, and therefore
should only be used in conjunction with other types of treatment (Block, 1997).

Treatment laws in which mentally ill juveniles are forced to take medication have recently changed. In order to mandate the taking of medication it is now required that mentally ill persons be a danger to themselves or others before the state will intercede on their behalf. When mentally ill juveniles stop taking their medication, nothing can be done until the juvenile becomes dangerous. When this happens, law enforcement takes over and mentally ill juveniles become incarcerated without proper mental health treatment. Thus, it is a losing battle for those suffering from a mental illness. If the laws changed to focus more on the need for mental health treatment, there would be substantially less mentally ill juveniles incarcerated (Faust, 2003).

Deinstitutionalization

With the 1960s came "deinstitutionalization," the idea that people should be released from hospitals on medication, in order to properly care for themselves (Serafini, 2002). Community mental health programs would treat the mentally ill, enabling them to live independently. According to Aufderheide & Brown (2005),
deinstitutionalization was a good vision, but it was unrealistic since the federal government failed to fund the programs. Deinstitutionalization was not meant to put mentally ill people into homeless shelters, incarcerate them, or leave them on the streets. However, that is the current trend due to the lack of supervised and subsidized housing for the mentally ill (Serafini, 2002).

Cost of Treatment

In order to be able to provide mental health treatment, there must be sufficient funds allotted for it. The cost of treatment is a definite concern among the parents of mentally ill juveniles. If they are unable to pay for mental health treatment, they are left with few viable options for caring for their mentally ill child. It is not uncommon for parents to relinquish custody of their children to the state in order for them to receive mental health treatment. Parents view transfers of custody as a last resort, however, the state makes it difficult for parents to resist due to the outrageous costs of healthcare. The National Institute of Mental Health reported that
The practice of transfer of custody as a requirement for receiving financial aid [for children with serious emotional disorders] occurs in a majority of states, though the actual extent of this practice is not known. The major factor influencing the use of transfer of custody appears to be the absence of an appropriate and adequate system of services for children and adolescents with serious emotional disorders. (Ginsburg & Demeranville, 1999, p. 19)

In 2001 the General Accounting Office discovered that 12,700 children suffering from a mental illness were surrendered to the state because their parents could not afford adequate health care (Jansen, 2004).

According to the Bazelon Center for Mental Health Law, from 1990 to 1997, states spent 33% of their funding on mental health while they spent 68% on corrections. In addition, from 1955 to 1997, the amount spent on mental health decreased by $5 billion (Serafini, 2002).

Cost has become a realistic problem when it comes to dealing with the mentally ill. At first glance, correctional facilities have outrageous costs even without funding programs designed to treat the mentally ill (Clear,
as cited in Lurigio, 1996). Since the funds are insufficient for mental health facilities, the preferred option has been to place juveniles suffering from a mental illness into correctional facilities. This results in major expenses for the correctional facilities (Faust, 2003). On average, correctional facilities spend $100 million a year to house juveniles awaiting mental health treatment (Jansen, 2004).

Lack of Funding and Resources

Although the federal government financially assists states with mental health care, it is primarily the states' responsibility for funding mental health programs. State and local jurisdictions contribute almost 30% to these funds, while the federal government pays about 25% of the cost.

Funding appears to be a significant problem with few solutions. Additionally, available funds continue to decrease. Those who are mentally ill endure the hardships of insufficient funds (Serafini, 2002). This lack of funding makes it difficult to ease the problem of treating juvenile mental illness; when the funds run out, juveniles are referred to programs other than those designed to treat
mental illness such as child welfare services or the juvenile justice system (Biggins & Oss, 2003).

At present, these necessary funds are out of reach, and without them, the criminal justice system and those in need suffer (Clear, as cited in Lurigio, 1996). Due to the lack of funding allotted solely for health care, mental health treatment is more available in correctional facilities than in mental health facilities. The 1970s brought about a significant decrease in funding. The programs that were cut were specifically designed for mentally ill juveniles and inmates. Due to this lack of funding, many mentally ill juveniles were either returned to society immediately after being medicated or supervised through outpatient treatment (McCarthy et al., 2001).

A significant number of facilities lack the resources needed to provide mental health treatment (Brogan, 2004). A lack of funding leads to less staff, more incarcerated juveniles, and a failure in treatment (Cannon & Beiser, 2004).

Since the mid 1950s, states have decreased the money used to fund mental health services by 30%, while the funding for prisons has increased dramatically. As a
result, many mentally ill juveniles end up on the streets or in correctional facilities (Serafini, 2002).

A lack of resources coexists with a lack of funding. Serafini (2002) found that a psychiatrist typically sees mentally ill patients once every two months for 15 minutes each session. Following those sessions, the patient spends another 15 minutes with a social worker. These therapy sessions are ineffective and provide little relief due to the inconsistency of the sessions.

Insurance

Insurance companies are now limiting what services are covered and are reducing funds paid to inpatient and outpatient services. This has resulted in less money being paid to mental health facilities, and therefore, a number of mental-health workers are resigning due to lower wages. Although insurance can be helpful, approximately 39 million Americans are uninsured; insurance only benefits those who can afford it, and therefore, fails to assist those who cannot (Serafini, 2002).

Nelson Smith is a good example of what happens when insurance companies limit the services that are covered. He was 17 years old when his mother relinquished custody of him to the state of Louisiana so that he could be treated
for his mental illness. His mother could not afford to pay for his outpatient treatment because his insurance company limited his mental healthcare allowance. He was moved from residential programs to correctional facilities, where instead of being offered treatment he was abused and neglected. Despite his serious mental illness he was rarely medicated. This could have been avoided if insurance companies would be more willing to provide adequate funds for mental healthcare (Ginsburg & Demeranville, 1999).

Insurance companies are not alone in their failure to provide for these juveniles. Medicare and Medicaid have limitations on their clients' treatment options. Medicare refuses to pay for prescription drugs unless the client is hospitalized, and Medicaid limits what mental health services they cover. This makes it difficult for the mentally ill to utilize these benefits (Serafini, 2002).

A significant problem regarding insurance is that many companies deny mental health care. When a person is physically injured, he or she generally has no problem receiving care, which is covered by the insurance company. However, a person suffering from a mental illness needs
pre-certification from the insurance company before any treatment can be administered (Serafini, 2002).

According to most insurance companies, and especially for Medicare, a physical illness and a mental health problem are viewed as unequal. While a patient treated for a physical illness pays 20% of the total cost, a patient receiving treatment for a mental illness pays half of the cost. Some of the members of Congress are strong advocates for equal coverage of mental health treatment through insurance companies. They are investigating renewing and increasing the mental-health parity law, which assisted those in need of mental-health services who could not afford them. Although somewhat helpful, the law was not effective enough to have a lasting impact because it failed to cover all aspects of mental illness (Serafini, 2002).

Improving health care would in turn create a ripple effect. If primary care physicians were trained in recognizing and treating mental illness, substantially less mentally ill juveniles would enter the juvenile justice system because they would have been previously diagnosed and offered treatment (Serafini, 2002).
Intervention

Prior to incarceration, there needs to be some type of intervention for mentally ill juveniles in order to prevent them from being detained in correctional facilities, where treatment is nearly nonexistent, especially for those juveniles who have not committed a crime (Serafini, 2002).

Alternatives to Incarceration

There are certainly alternatives to incarcerating mentally ill juveniles. Those suffering from a mental illness do not necessarily need to be incarcerated. Even for those who have committed crimes, incarceration is not the only option. Effective alternatives that focus on treatment exist and have proven to be more successful than incarceration. While a number of these alternatives have failed, there are programs that have been shown to be successful (Clear, as cited in Lurigio, 1996).

The National Alliance for the Mentally Ill (NAMI) developed a Crisis Intervention Team (CIT) to work closely with police departments in the area of Fort Wayne, Indiana. In 2003, CIT had over 1,000 interventions, with more than 800 of the interventions resulting in hospitalization. As a result of the program, only six arrests occurred and there were no deaths. This successful program is being
emulated throughout the state. The success of this program is credited to the CIT officers who have been trained to deal with the unusual behavior of the mentally ill. As a result, less mentally ill people are arrested, which leads to less of them being incarcerated (Bayes, 2004).

The Carriage House Clubhouse was developed in Indiana and has proven to be an ideal rehabilitation program for the mentally ill (Bayes, 2004). It is a community center that provides support and assistance; the program is voluntary and is intended to provide those in need with resources to attend school or obtain employment. According to Karen Francisco, a writer for the Journal-Gazette, "It's an invaluable program that helps to ensure that those in our community with persistent mental illness can still contribute" (Francisco, 2004, pg. 8A+). The impact of the Carriage House Clubhouse program is that people who have a mental illness who were previously turned away from treatment are now receiving treatment. An added result is that while receiving this treatment, the mentally ill remain docile, are not in need of incarceration, and are able to live "normal" and productive lives (Bayes, 2004).

For the crime rate of mentally ill juveniles to decrease, all of the following need to be achieved: First,
mentally ill juveniles need to have alternatives to incarceration. Correctional facilities are designed for offenders and are not properly equipped or adequately designed to house mentally ill juveniles. Second, victimization of mentally ill offenders by citizens and institutions needs to be eliminated. Third, it is important for those who suffer from a mental illness to be provided with a support system, even if it is through the correctional system. If these goals can be attained, mentally ill juveniles have a chance to be productive members of society (Clear, as cited in Lurigio, 1996).

Training for Correctional Officers

In order to productively supervise mentally ill offenders it is important that correctional officers who come in contact with mentally ill offenders receive mental health training. Presently, staff employed in correctional facilities generally receive minimal or no training on mental illness ("Training for Corrections Personnel," no date). Mentally ill juveniles are difficult and require more supervision; often times, they become easily disturbed and act out violently (Jansen, 2004).

Basic correctional training fails to prepare correctional officers for the challenges of mentally ill
juvenile offenders in their custody. For example, Leonard Dixon, who directs the Juvenile Detention Facility in Wayne County, Michigan, stated:

You cannot cripple a person and then criticize the way that they walk. When we place children in institutions without having the proper services for them, then we’re asking the facilities to perform at a level that they are not capable of doing. (Jansen, 2004, A1+)

There are a variety of recommended training programs that should be offered and implemented for correctional officers who come in contact with mentally ill offenders. In order to effectively treat mentally ill juveniles, it is imperative that the staff be trained properly, such that they have a clear understanding of the special needs and background of the inmates. Staff should have a basic knowledge of mental illness in order to recognize those who are mentally ill and be able to refer them to the appropriate services, including diagnosis and evaluation. Staff should also be trained to identify warning signs of mental health problems and substance abuse (Norton, 2005).

Additionally, it is important for the staff to have knowledge of the various drugs used to treat such
individuals, as correctional officers are sometimes given the responsibility to administer prescribed medications (Norton, 2005). These officers should also be able to determine when an offender has a bad reaction to the administered medication. It is necessary, therefore, that staff members work closely with mental health treatment providers in order to effectively treat these juveniles (Clear, as cited in Lurigio, 1996).

Correctional officers should have a general understanding of how to properly interact with mentally ill offenders, as well as have a clear understanding of effective communication techniques (Clear, as cited in Lurigio, 1996). The officers should be offered counseling techniques, for example, in order to prevent suicide attempts. Regardless of their backgrounds, staff who interact with inmates who suffer from a mental illness should be trained how to handle them ("Training for Corrections Personnel," no date).

A number of states have created policies that call for mental health training for correctional officers. In one illustrative program in Virginia, the Department of Corrections has employed a mental health training coordinator to teach a mandatory mental health training
program for their institutional and clinical staff. The Department of Corrections in Oregon, trains their correctional officers and their mental health staff together in order to provide the correctional officers with a better understanding of mental illness (Training for Corrections Personnel," no date).

Existing training for correctional officers should include many of the above suggestions for the special handling of mentally ill juvenile offenders. Many positive outcomes could be achieved through enhanced training. Correctional officers who come in contact with mentally ill offenders, for example, are at higher risk for injury and could be trained how to effectively mollify tense or hostile situations, while still maintaining officer safety. In fact, both the safety of all of the juveniles in the facility and the safety of the staff serve as an important motivation for additional officer training in mental health issues (Training for Corrections Personnel," no date).
CHAPTER THREE

METHODS

Research Design

Since very little prior research has been done in this area, the primary purpose of this study was exploratory and descriptive. This type of methodology was used to effectively ascertain a better understanding of mentally ill juvenile offenders from the participants. A qualitative research design was employed in order to reach the target population, as well as, to know and understand the experiences of professionals in the criminal justice field. Compared to quantitative data, qualitative data provides a more thorough definition of the research, since this type of research design allows the participants' responses to be better expressed throughout the study (Maxfield & Babbie, 2001).

While qualitative methodology is practical and valid, it has a number of disadvantages. First, when using qualitative field research, there is always the possibility that the research will not be reliable because the participants' responses are reflected through the researcher's own experiences and observations. Although
responses may be characterized a certain way by one researcher, it does not mean that a different researcher would characterize the responses in the same fashion. While researchers are able to personalize their observations, there is a possibility that other researchers would not simulate the results. This thus compromises the reliability of the final product (Maxfield & Babbie, 2001).

Another problem with qualitative methodology is generalizability, which is the difficulty in drawing general conclusions. This can occur because the readers may be more concerned with what the entire population thinks rather than a small number of participants within the general population. Also, since researchers are able to grasp an inclusive understanding of their responses, the understanding becomes less generalizable than if the research was based on a large sample (Maxfield & Babbie, 2001). Despite these limitations, qualitative research does provide an effective means to conduct the research and obtain valuable results.

An important part of this study was to discover if treatment for mentally ill juveniles is thought to be adequate, and, if not, to suggest possible improvements. Various aspects of the criminal justice system were
studied. In part, this research examined treatment of mentally ill juveniles as well as laws regarding treatment. 

Subjects

Criminal justice professionals who work with mentally ill juvenile offenders were interviewed. Subjects who agreed to participate included probation officers, probation corrections officers (PCO’s), a clinical therapist, and a superior court judge sitting as a juvenile court judge. Six females and four males participated ranging in age from 23 years old to 59 years old. In terms of time in their current position, the range was from 3 weeks to 15 years. Altogether, their experience in dealing with mentally ill juveniles ranged from 2 weeks to 25 years. The subjects were selected through convenience sampling, in that individuals who were available and easily accessible were asked to participate in this study.

The probation officers interviewed work solely with juvenile offenders, and mostly those juvenile offenders who are not incarcerated; the number of mentally ill juveniles on their caseload varied among the sample. The probation officers refer the mentally ill juveniles on their caseloads to available treatment programs. The ultimate
goal is to manage and control the difficult behavior of the mentally ill juvenile offenders in the community.

The PCO’s interviewed work at a juvenile correctional facility and only work with juvenile offenders. Although the majority of juvenile offenders detained at the facility do not suffer from a mental disorder, all of the PCO’s interviewed reported some experience in dealing with mentally ill juveniles through their employment. Although PCO’s have the option to refer the mentally ill juveniles to treatment programs, the treatment is often limited and scarce, which limits such referrals.

The superior court judge sitting as a juvenile court judge works primarily with juvenile offenders. He recently began presiding over Mental Health Court and now deals with mentally ill juvenile offenders as well. He is able to provide a different perspective to this study, since he determines the fate of the mentally ill juveniles who enter his courtroom. This can be mental health treatment or incarceration. The judge is a strong advocate for mental health treatment of mentally ill juveniles, however he realizes that he is limited in his referral options.

The clinical therapist was selected because she primarily works with detained juveniles and almost
exclusively works with mentally ill juveniles. She was able to provide a treatment perspective to this study as well as discuss different types of counseling programs.

Access

Due to my employment as a probation officer and my previous employment as a PCO, it was fairly easy to gain access to the participants. For the probation officers, permission was obtained through my Division Director II. He then contacted the Division Director II for the juvenile correctional facility, who granted me permission to interview the PCO’s and the clinical therapist. A co-worker who is currently assigned as a court officer, arranged for access to the judge. He notified the judge of my request to conduct an interview, and the judge agreed to participate.

The interviews were voluntary and the participants were asked to participate and not offered any compensation. They were interested in contributing to the goals of this thesis in expanding the topic of mentally ill juvenile offenders. As such, the majority of the participants expressed interest in gaining access to the results of the study, in order to increase knowledge of mentally ill juveniles and to potentially increase the availability of
treatment programs. An additional benefit for the participants in contributing to this study includes the possibility that their input may have an impact on how mentally ill juveniles are dealt with in the future. This in turn could reduce the number of mentally ill juveniles who come in contact with law enforcement, or at a minimum, could force the proper handling of mentally ill juveniles within the criminal justice system.

Confidentiality was used rather than anonymity to insure that the researcher could confirm the identities of each participant. This was required so that certain responses could be attributed to different sources. All of the participants were assured that their identity would be kept confidential to elaborate their responses and allow them to remain comfortable throughout the interviews.

Setting

The interviews were conducted one at a time, face-to-face, at the participant’s place of employment. The probation officers were interviewed at the Probation Department while the PCO’s and the clinical therapist were interviewed at the juvenile correctional facility. The judge was interviewed in his chambers. Each interview lasted approximately 20 minutes.
Interview Questions

The participants were asked 15 to 18 questions relating to mentally ill juveniles. The questions focused on the types of treatment available and the types of crimes mentally ill juvenile offenders commit compared to non-mentally ill juvenile offenders. The participants were also asked to provide examples of their interactions with mentally ill juveniles. Many of the participants relayed interesting stories detailing their experiences with mentally ill juveniles.

The majority of the questions were open-ended to encourage the participants to expand their answers and not limit their responses. The questions primarily sought to discover how the participants come in contact with mentally ill juvenile offenders. Ultimately, the questions attempted to discover if mentally ill juveniles are treated differently from non-mentally ill juveniles, and if they receive adequate treatment in correctional facilities. Refer to Appendix A through C for the exact questions asked during the interviews.

Limitations

As stated earlier, there are several limitations to this study. The first limitation is generalizability or
sample size; the number of participants used in this study does not represent the entire population, and therefore, can only provide a glimpse of what a larger number of participants might have offered. The type of participants used in this study is another limitation. Only criminal justice professionals were examined, limiting the types of responses and not allowing for a comparison group of professionals in other fields. The method of selecting participants through convenience sampling also limited the generalizability of the study.

The next limitation involves the questions that were asked. Although many of the questions were open-ended to encourage elaborate responses, several of the questions called for and received limited responses.

Another limitation is the issue of reliability. Since many researchers include their personal experiences when conducting a study, it is difficult to determine if another researcher would share the same experiences if the study were repeated.

Despite these limitations, this study offers considerable and valuable information and provides a prototype for more extensive research. In particular, it provides specific information on the treatment of mentally
ill juvenile offenders from a variety of aspects within the criminal justice system. Despite the small sample size, this study attempts to provide, through experiences and perspectives of the participants, a better understanding of the issues concerning mentally ill juvenile offenders.
CHAPTER FOUR

ANALYSIS

Study Findings

Only adult professionals in the criminal justice field were interviewed for the purpose of this study. A more thorough overview of the participants will be provided including a description of job duties, experience in dealing with mentally ill juveniles, and demographic information. Stories that reflect the participants’ interactions with mentally ill juveniles will be discussed. Treatment programs in correctional facilities and in the community will be examined as well their effectiveness. The process of diagnosing and evaluating mentally ill juvenile offenders will also be described.

Participants

There were 10 participants in this study. Of the four probation officers interviewed, the first participant interviewed was a 31-year-old African American male. He has been a probation officer for eight years and has worked with mentally ill juveniles the entire time. He also has a Juris Doctorate Degree. The second participant is a 32-year-old Hispanic female. Although she has only been in
her current position for four years, she has nine years of experience in dealing with mentally ill juveniles. She has a Bachelor's and a Master's Degree. The next participant is a 49-year-old Hispanic male. He has been in his current position for two and one half years, however, he has worked with mentally ill juveniles for over four years. He also possesses a Bachelor's Degree. The last of the probation officers interviewed is a 31-year-old Caucasian female. She has been in her current position for just over one year, however, she has been working with mentally ill juveniles for over five years. She also has a Bachelor's Degree.

Of the four PCO's interviewed, the first participant is a 33-year-old Hispanic female. Although she has spent the last four years in her current position she has only worked with mentally ill juveniles for three of those four years. She currently has two Associate's Degrees and is in the process of earning a Bachelor's Degree. The second participant is a 23-year-old Hispanic female. Although she has been in her current position for three weeks she only has two weeks of experience in dealing with mentally ill juveniles. She has an Associate's Degree and is in the progress of earning a Bachelor's Degree. The next
participant is a 31-year-old Hispanic female. She has been in her current position for five years and has worked with mentally ill juveniles the entire time. She currently has an Associate’s Degree. The last of the PCO’s interviewed is a 46-year-old Hispanic male. He has been in his current position for seven months and has spent six of the last seven months working with mentally ill juveniles. He currently has an Associate’s Degree.

The superior court judge sitting as a juvenile court judge is a 59-year-old Caucasian male. He has held his current position for 15 years, and six months ago he began working with mentally ill juveniles. He also has a Juris Doctorate Degree.

The clinical therapist is a 56-year-old Caucasian female. Although she has only held her current position for 10 years she has worked with mentally ill juveniles for 25 years. She has a Bachelor’s and a Master’s Degree.

Job Description and Duties

All of the participants work primarily, if not exclusively, with juvenile offenders. Depending on the assignment, some of the offenders are incarcerated, while others are not. Despite the similarity of working with
juvenile offenders, all of the participants vary in their job duties.

The probation officers’ duties include writing reports for the court, monitoring the behavior of juvenile offenders, including those who are mentally ill, and ensuring compliance of court orders, such as drug and alcohol counseling, therapy, and anger management counseling. These probation officers also conduct home visits to ensure compliance of the law, speak with the juveniles’ parents, and counsel both the juveniles and their parents. They also encourage the juveniles’ scholastic potential by speaking with school officials, checking their grades, and ensuring they are attending school on a regular basis.

The PCO’s primary duty is to maintain and ensure the safety of the juveniles and the staff at the juvenile correctional facility. In addition, the PCO’s also assist juveniles in their daily living skills, ensure that the juveniles maintain appropriate hygiene, eating, and sleeping habits, and attend to their needs, both physical and emotional. The PCO’s also ensure compliance of the unit rules and conduct anger management counseling
sessions, as well as group and individual counseling sessions.

The judge’s job duties differ dramatically from that of the probation officers and the PCO’s. The judge handles the pretrials and trials for alleged juvenile offenders. He recently added Mental Health Court to his monthly calendar and now hears the cases of juveniles whose attorneys have expressed doubt regarding their competency to stand trial.

The clinical therapist’s duties consist of receiving and handling referrals for mentally ill juvenile offenders or juvenile offenders with psychiatric disorders. The therapist also makes referrals to psychiatrists to ensure that these juveniles are issued their necessary medications. She provides assessments of mentally ill juvenile offenders to determine if they should be placed on suicide watches, which range in levels from minimum to maximum. She also offers crisis intervention counseling to those juveniles in need.

Experience With Mentally Ill Juveniles

All of the participants have experience in dealing with mentally ill juveniles. The probation officers agreed that they have mentally ill juveniles on their caseloads;
however, the two female officers claimed that the majority of their caseloads are mentally ill, while the two male officers claimed that the majority of their caseloads are not mentally ill. The PCO’s also agreed that they have mentally ill juveniles in the juvenile correctional facility, however, three of them claimed to have only a small number of mentally ill juvenile offenders on their units. The superior court judge insisted that the main part of his calendar is non-mentally ill and claimed to see only a few mentally ill juveniles each month. In contrast, the clinical therapist sees mostly mentally ill juveniles, and the ones who are not mentally ill have some type of emotional problem that needs to be addressed.

Diagnosis and Evaluation

More than half of the participants reported that mentally ill juveniles are evaluated almost immediately when there is evidence of a mental disorder. When mentally ill juvenile offenders come in contact with the criminal justice system, generally after committing a crime, it is evident from the probation files that they have a mental disorder. All of the probation officers claimed that the mentally ill juveniles on their caseloads were previously diagnosed and evaluated by a psychologist. Two of the
probation officers, the eight-year veteran male and the nine-year veteran female, added that in addition to the psychological evaluations found in the probation files, their own personal observations allow them to determine if the juveniles on their caseloads are mentally ill. The PCO’s reported that a psychologist has previously evaluated most of the mentally ill juveniles they have come in contact with. On the contrary, the clinical therapist reported that half of the mentally ill juveniles she sees are not previously evaluated. Those who have been previously evaluated were evaluated through their school, an Individualized Education Plan (IEP), an outside psychologist, or an in-patient psychiatric facility.

Acting out Behavior

Many of the participants reported violent behavior displayed by the mentally ill juveniles either toward others or themselves. One respondent, the five-year veteran female probation officer, discussed a 15-year-old female diagnosed with Bipolar Disorder, who cut both of her arms from the elbow to the wrist, 30 times on each side, and then cut both of her legs from the knee to the groin area, 50 times on each side. Her medication was increased in an attempt to better control her behavior. This
improved her behavior, however, "the medication made her a walking zombie."

Another participant, a four-year veteran female PCO, discussed a female mentally ill juvenile who wanted constant attention from the staff, "she took feces from the toilet bowl and put it in her sock." The same PCO discussed another female juvenile who also craved attention; she made herself bleed and then covered the walls in her room with her blood. The four-year veteran male probation officer discussed a 14-year-old male juvenile diagnosed with a neurological disorder who had been seen by numerous psychologists:

He repeatedly threatened to kill his entire family, and on several occasions his mother woke up during the night and discovered him standing by her bed. He attacked his therapist and was sent to a residential placement facility where he attacked another therapist. He is now confined to a mental institution.

The eight-year veteran male probation officer discussed a suicidal female suffering from a mental illness. Due to a history of attempted suicides, including a previous attempt by slitting her wrists and ingesting
sleeping pills, her probation was violated and she was taken to the juvenile correctional facility. It was determined that she was suicidal and she was transported to Arrowhead Behavioral Health Center. After meeting with a psychologist, she was able to better understand her condition and accept preventive measures to keep her from subsequent suicide attempts.

While attempting suicide is a common characteristic of many mental disorders, often times juveniles suffering from a mental disorder are violent to others rather than to themselves. The judge recalled a 16-year-old female diagnosed with Paranoid Schizophrenia and Bipolar Disorder.

She was extremely violent and was found incompetent to stand trial. She is now being treated in a mental health facility and although there is a prognosis for positive results it will take a significant amount of time to see them.

The clinical therapist discussed a 16-year-old female juvenile with Borderline Personality Disorder and severe depression. She was suicidal and self-abusive and would cut herself on her genitals.

Although violence and attempted suicide are common occurrences among mentally ill juveniles, there are also
mentally ill juveniles who act out in other ways. The rookie female PCO discussed a mentally ill male juvenile who displayed bizarre behavior while in custody. "One day he was fine and then all of a sudden he became extremely upset, dropped to his knees, and started praying." The same juvenile on a different occasion tried to commit suicide by putting a sock around his neck. Bizarre behavior seems to be a regular occurrence among mentally ill juvenile offenders in juvenile hall. The six-month rookie male PCO discussed a male juvenile suffering from a mental illness. "He used to talk to himself frequently. He said he was talking to his friends. On one occasion, he took off all of his clothes and ran around the unit naked."

Mentally ill juveniles who are released into society and placed on probation can also become violent. The four-year veteran female probation officer discussed a male juvenile suffering from a mental condition. She went to his house to talk to him and discovered that he had been violent. She directed him to put his hands behind his back. Rather than complying he began struggling with her and had to be tackled to the ground in order for him to be handcuffed.
Often, mentally ill juveniles act differently than non-mentally ill juveniles. The clinical therapist has observed significant differences in the types of behavior displayed by mentally ill and non-mentally ill juvenile offenders. Mentally ill juvenile offenders tend to have more difficulty adjusting to the correctional setting and have a harder time following structure such as proper hygiene and following staff directives. They are more impulsive, angry, and hopeless, and tend to become depressed more quickly. Non-mentally ill juvenile offenders occasionally have problems, however, they can be easily redirected.

Types of Crimes

In general, according to the participants, mentally ill juvenile offenders differ in the types of crimes they commit compared to non-mentally ill juvenile offenders. Three probation officers, three PCO's, and the judge saw a considerable difference in the types of crimes committed between the two groups. Those seven participants reported that mentally ill juveniles tend to commit more heinous and violent crimes such as murder, kidnapping, and assault, as compared with theft and drug related crimes committed by non-mentally ill juveniles. The two male probation
officers and the judge suggested that mentally ill juveniles commit crimes with no regard for their victims and no thought of future consequences. They claimed that mentally ill juveniles justify their actions to themselves and are not capable of realizing they have done anything wrong.

**Treatment**

While each of the participants could recall some type of treatment offered to mentally ill juveniles, whether in a juvenile correctional facility or in the community, only four of the participants, two probation officers and two PCO’s, thought the treatment that is currently available is sufficient. Of those, the eight-year veteran male probation officer reported that while the current treatment that is available is sufficient, "the difficulty is determining what type will work for each juvenile and finding a medium with drugs that will control them, but not put them in a depressive state."

The three-year veteran female PCO thinks the treatment is sufficient when the juveniles are classified appropriately. Two of the PCO’s complained that the mentally ill juveniles in juvenile correctional facilities should not be there and instead should be housed in a
mental institution with professional staff who are trained properly to deal with them.

The clinical therapist suggested different types of available treatment in Juvenile Hall such as the Juvenile Justice Outpatient Program (JJOP) and the Juvenile Evaluation Treatment Services (JETS), both of which provide counseling services through supportive treatment. She also suggested crisis intervention counseling and cognitive behavioral treatment. On the negative side, Juvenile Hall is incapable of providing long-term treatment as the therapists have no control over the juveniles' environment and the juveniles' custody time is indeterminate.

Despite the variety of treatments available, the clinical therapist was certain that the treatment is insufficient since it does not cover all types of disorders. In addition, she reported that mentally ill juveniles do not receive drug and alcohol counseling as part of their treatment while they are detained in Juvenile Hall.

The majority of the participants were confident that the treatment available for mentally ill juveniles is inadequate. The nine-year veteran female probation officer blamed a lack of funds as the reason for the lack of
treatment. She reported, "the lower economic kids do not have as many programs available. The juveniles who cannot afford treatment suffer because of their economic status." Just like welfare provides services to those who cannot afford them, mental health treatment should be available to poor mentally ill juveniles.

Although they think the offered mental health treatment is inadequate, two of the PCO’s and one of the probation officers believe that it is easily accessible. The four-year veteran male probation officer stated that treatment is easily accessible for mentally ill juveniles as long as their parents can afford it. Unfortunately, many of the parents cannot. The three-year veteran female PCO stated that treatment is,

very easily accessible. Drugs are prescribed too quickly and easily. The juveniles have figured out what symptoms they need to have to be given medication. I have had kids who faked their symptoms to obtain medication.

The clinical therapist felt strongly that there are mentally ill juveniles who "fall through the cracks and get hurt." On the contrary, the judge thinks the main difficulty of mentally ill juveniles getting into treatment
programs is that, “many juveniles are diagnosed with behavior problems and cannot be helped because the Department of Behavioral Health does not view them [behavior problems] as mental disorders.”

Of the three participants who thought that treatment is adequate, the eight-year veteran male and the five-year veteran female probation officers also reported that there are several programs available for mentally ill juveniles. Even if they cannot afford them, there are various grants available that can be used to fund the programs.

**Treatment Laws and Policies**

There are few laws regarding the treatment of mentally ill juveniles. Eight of the participants agreed that laws concerning treatment of mentally ill juveniles should change. Two probation officers, a PCO, and the judge were not aware of any laws that currently exist for juveniles. The judge would like to see comprehensive laws developed so that mentally ill juveniles can receive better treatment. Currently, the judge has no authority to insist that mentally ill juveniles are treated, since that authority lies with the parents. He would like to see laws enacted that would enable juveniles suffering from a mental illness
to be able to receive treatment regardless of consent from their parents.

A probation officer and two PCO’s felt strongly about laws being enacted to provide better training for staff who work with mentally ill juveniles, and to have a specialized mental health unit for mentally ill juvenile offenders. The five-year veteran female probation officer reported that she would like to see a statewide set of guidelines created that would require probation officers to have regular training in dealing with mentally ill juveniles, including a set of standards on how they should be treated. The five-year veteran female and the four-year veteran male probation officers as well as the rookie female PCO would like to see programs created, and for mentally ill juveniles to have better access to those programs regardless of their financial resources.

In regards to policies for mentally ill juveniles, two probation officers and two PCO’s would like to see specialized mental health units created and have probation officers work closely with the Department of Behavioral Health. Two of the probation officers would like to see county funds become accessible to ensure that treatment is available for the juveniles who need it. The three-year
veteran female PCO would like a policy to be created to keep mentally ill juveniles who are a danger to themselves or others to be confined to a mental health facility rather than transferred to juvenile hall.

Programs in Correctional Facilities

Unfortunately, many of these juveniles are in juvenile correctional facilities without specific programs for treating mentally ill juveniles. Only half of the participants were aware of specific programs available for mentally ill juveniles in correctional facilities. As a result, these juveniles are incarcerated with little or no hope of receiving treatment. The eight-year veteran male probation officer and the judge agreed that the California Youth Authority (CYA), a juvenile prison, has a number of beneficial programs for mentally ill juveniles, including individual and group counseling as well as an onsite psychologist. However, in general, juveniles must commit serious crimes to be sent there, which does not benefit the mentally ill juveniles with little or no criminal record. Two of the female PCO’s and one of the male probation officers agreed that Juvenile Hall has JJOP and JETS for mentally ill juveniles. They were not aware of any
additional programs specifically designed for these juveniles.

Aftercare

All of the probation officers agreed that for mentally ill juveniles to remain stabilized, it is important for them to be regularly medicated and to be seen by a psychologist. The eight-year veteran male reported that 70% of the mentally ill juveniles on his caseload see a general therapist on a regular basis, however, a psychologist rarely sees them, and they are not regularly medicated. This is usually "because the juveniles or their parents do not want them taking it." The nine-year veteran female probation officer agreed that the juveniles on her caseload are rarely medicated; however, she reported that only some of the juveniles on her caseload refuse to take their medication and that half of them simply cannot afford it. The four-year veteran male probation officer stated that the mentally ill juveniles on his caseload are regularly seen and medicated, however, if they are not, he refers them to the appropriate services. The five-year veteran female probation officer was confident that the mentally ill juveniles on her caseload are seen and
medicated regularly; if they fail to do so, they violate their probation and are sent to Juvenile Hall.

The PCO’s differed dramatically in their opinions of whether mentally ill juveniles detained in Juvenile Hall are regularly medicated and seen by a psychologist. The four of them agreed that the juveniles in juvenile correctional facilities are medicated daily, sometimes, several times a day. The two rookie PCO’s also agreed that a psychologist regularly sees the juveniles.

The clinical therapist reported that she does not medicate the mentally ill juveniles who are referred to her. When they are medicated JJOP or JETS usually sees them. JJOP or JETS usually see them once a week; however, the juveniles who are in crisis intervention counseling are seen more frequently, depending on medical necessity.

Parents of Mentally Ill Juveniles

While the four probation officers agreed that they interact with parents of mentally ill juveniles, only one of the PCO’s could recall any type of experience in dealing with them. The three-year veteran female PCO described the parents as being supportive in their desire for their children to act “normal.” The probation officers all reported that most of the parents are supportive of their
children and are cooperative with the Probation Department. The five-year veteran female probation officer stated that the parents are advocates for medication and are relieved when their children are taking it. She further explained that some of the parents are fearful of their children when they are not medicated. The nine-year veteran female probation officer discussed parents who are not concerned with their children’s diagnosis or are in denial regarding it. Those parents do not want to accept that their children have a mental illness, out of fear that they have failed their children or have been bad parents.

The clinical therapist also described parents who do not care about their children’s mental conditions. She reported, however, that parents differ substantially as to whether their children should be medicated. In general, the parents who do not want their children medicated also want little or nothing to do with their children, while the parents whose children are taking medication tend to be more supportive. Unfortunately, it seems that the parents want a “quick fix” to the problem and do not want to contribute to finding a solution.
Probation Department’s Handling of Mentally Ill Juveniles

While it may not seem a common practice that mentally ill juvenile offenders are treated differently than non-mentally ill juvenile offenders by the Probation Department, the majority of the participants expressed some differences. All of the probation officers and three of the PCO’s reported that mentally ill juveniles receive more attention and supervision. The three-year veteran female PCO stated:

the staff tend to not be as comfortable around mentally ill juveniles.... The staff are more alert all of time. They are constantly watching the juveniles’ faces, attitudes, everything.

The five-year veteran female probation officer gives the mentally ill juveniles on her caseload more opportunities and tends to be more patient with them. They are given more time to complete their conditions of probation, such as community service; however, if they become violent they are arrested immediately. The four-year veteran male probation officer gives the mentally ill juveniles on his caseload more time and attention because,
“they are like little kids. If they know they are being watched constantly, it becomes a deterrent.”

Training

Although training on how to handle mentally ill juveniles is extremely important, the majority of the participants have never been offered specific training in this area. The nine-year veteran female and the four-year veteran male probation officers described training they had through previous employers; however, neither of them could recall any recent training. The three-year veteran female PCO denied ever being offered training, however, she is currently majoring in psychology, which has been helpful during her employment at the juvenile correctional facility. In addition, she has been involved in external programs where she worked closely with therapists. The eight-year veteran male probation officer could not recall any specific training and stated that he relies on common sense to figure out how to handle the mentally ill juveniles on his caseload.

The judge has not been offered any mental health training and took it upon himself to contact other judges who specialize in mental health. He has also received assistance from attorneys; however, he reported that he
"learns something new everyday." In contrast, the clinical therapist has received a significant amount of training for dealing with mentally ill juveniles. She has a degree in chemical dependency counseling and has annual training workshops and conferences regarding mentally ill juveniles. In addition, she has a private practice and does individual and family counseling for both juveniles and adults.
CHAPTER FIVE

CONCLUSION

Mental illness in juveniles, especially in juvenile offenders, is a serious problem. It is difficult for mentally ill juveniles to be evaluated and diagnosed due to a lack of trained professionals and a lack of funding. Even with a diagnosis, it is difficult for them to receive mental health treatment due to a lack of available services (Serafini, 2002).

Many mental health facilities are closing, while new prisons continue to open. Even the facilities that are open, house small numbers of patients due to a lack of funds. In contrast, some facilities are so overcrowded that there are lengthy waiting periods prior to admittance (Serafini, 2002).

Too many mentally ill juveniles are “falling between the cracks;” instead of receiving adequate mental health treatment in correctional facilities, they are being abused and mistreated. A significant number of mentally ill juveniles are detained in correctional facilities while awaiting treatment. Some have never committed a crime and are only housed there due to a lack of available resources.
These juveniles are detained longer than juvenile offenders and are forced to live in unbearable conditions (Serafini, 2002).

Many of these mentally ill juveniles could lead "normal" and productive lives with the proper medications. However, many parents of mentally ill juveniles cannot afford medication, and many correctional facilities do not have adequate services to provide mental health treatment, which often includes medications. Parents of mentally ill juveniles are being encouraged, and sometimes forced, to relinquish custody of their children in order for them to receive treatment (Ginsburg & Demeranville, 1999).

There is a controversial issue regarding the use of medication as part of mental health treatment for mentally ill juveniles. On one hand, medication is necessary to treat a number of disorders, while on the other hand, medication can be addicting and can lead to serious problems. Through research, it was determined that medication is a necessary part of the treatment protocol; however, it is most beneficial if it is combined with other types of treatment such as counseling and behavior modification (Block, 1997). Also, it is important that a professional consistently regulates the medication taken by
mentally ill juveniles. Otherwise, medication can be abused or incorrectly administered.

It was discovered that some correctional facilities provide minimal treatment services in an attempt to address the problem of mental illness. Some of these facilities do not have onsite psychologists and the mentally ill juveniles are only seen on a monthly basis. In addition, there are some detained juveniles who are never seen by a psychiatrist (Serafini, 2002).

The lack of trained professionals who deal with mentally ill juveniles is another serious problem. Many of the correctional officers who work in juvenile correctional facilities receive minimal or no training on how to handle mentally ill juveniles; thus they are unprepared for the challenge of caring for mentally ill individuals. With improper care and attention, these juveniles are released back into society in worse mental conditions than before they were detained (Clear, as cited in Lurigio, 1996). If staff were properly trained, mentally ill juveniles could receive the benefits of treatment presented by trained professionals. This treatment could improve their lives, giving them advantages they may not have had otherwise.
Despite the lack of treatment offered in correctional facilities there are model programs offered elsewhere that have proven to be successful. For example, the Carriage House Clubhouse is a successful program developed in Indiana for the mentally ill. The program enables the mentally ill to participate in society through employment or school, thereby empowering the mentally ill to feel a sense of self-worth (Francisco, 2004). California could benefit tremendously from a similar program, because once created, the state could reduce the number of mentally ill juveniles who continue to enter the criminal justice system each year.

Ten adult professionals in the criminal justice field were interviewed in order to gain a better perspective of their experiences of working with mentally ill juveniles, and to discover if mental health treatment is actually effective at the facilities they come in contact with. From these interviews it was determined that mentally ill juveniles tend to commit more violent crimes than non-mentally ill juveniles. It was determined that mentally ill juveniles often display strange behavior, sometimes for attention, and at other times for no reason. The research
also discovered that mentally ill juveniles are more likely to attempt suicide or cut themselves repeatedly.

Many of the participants agreed that mentally ill juveniles are evaluated prior to law enforcement contact, and that these juveniles are regularly medicated and seen by a psychologist. The participants reflected that while some of the parents are supportive in the attempt to "fix" their children, a number of the parents are opposed to medicating them and are in denial regarding their children's illness.

The majority of the participants were not aware of laws that exist concerning mentally ill juveniles; they provided suggestions regarding what types of laws are needed including specialized mental health training for those who deal with mentally ill juveniles, and separate mental health units in correctional facilities. It was discovered through the interviews that there are limited programs available in correctional facilities for mentally ill juveniles and that juvenile prisons are better prepared for dealing with juveniles who suffer from a mental disorder.

Two main conclusions can be drawn from the interviews and the research. First, although mentally ill juveniles
are offered mental health treatment in Juvenile Hall and the community, the treatment is generally inadequate. In addition, there does not seem to be a balance between medication and other types of treatment; these juveniles are either overmedicated or not medicated enough. Second, those employed in the criminal justice system who handle and supervise mentally ill juvenile offenders are not offered any formal training in that area. All of the participants deal with mentally ill juveniles, and many of them are "clueless" when it comes to providing treatment services.

Although the research objective of this study was achieved, future research should be considered on this topic. Although the present research was qualitative, it might be beneficial for future research to incorporate quantitative research methods. In addition, it might be beneficial to determine how many mentally ill juveniles are actually incarcerated in correctional facilities across the country. Some of the research was narrowly focused, and only included a criminal justice aspect with opinions of criminal justice professionals. Future research should look at other aspects of mental health, including staff employed at mental health facilities, school psychologists,
and social workers. In addition, future research should be more generalizable and include a larger sample size to allow for more detailed results.

From the research examined, there are a number of policy implications that could be created to improve the treatment of mentally ill juveniles. Early intervention and diagnosis could prevent a large number of mentally ill juveniles from coming into contact with law enforcement. Schools should be provided with early educational tools to allow diagnosis and evaluation of mentally ill juveniles by employing onsite psychologists who make the initial diagnosis and who regularly re-evaluate these juveniles.

Mentally ill juvenile offenders should be housed in mental health facilities if available, and if not, should be housed in separate mental health units in correctional facilities. If they are not separated from non-mentally ill juvenile offenders, they are at-risk of being victimized by other juvenile offenders. The mental health units should be run by trained staff who are adequately prepared to handle these juveniles. The training should be specific on how to treat mentally ill juveniles and should be refreshed annually.
Correctional facilities that house mentally ill juveniles should have onsite psychologists who provide them with counseling and therapy on a regular basis. Juveniles suffering from a mental illness should be seen by a psychologist on a weekly basis. If properly treated and with continued aftercare, there is a substantial probability that many mentally ill juveniles could be released back into society as productive and "normal" functioning citizens.
APPENDIX A

INTERVIEW QUESTIONS FOR THE
PROBATION OFFICERS AND PROBATION CORRECTIONS OFFICERS
1. What is your job title? Describe your everyday duties?

2. Do you work with mentally ill juveniles? If so, how long have you worked with them? Upon what evidence are you basing your conclusion that they are mentally ill?

3. Do you work with non-mentally ill juveniles as well?

4. Can you give me an example of a specific incident where you handled a mentally ill juvenile?

5. Do you notice a difference in the types of crimes mentally ill juveniles commit as compared with non-mentally ill juveniles? If so, can you give some examples of those crimes?

6. What types of treatment are you aware of that are available to mentally ill juveniles, and do you think that they are sufficient?

7. How long does it take before a mentally ill juvenile is evaluated? Are they evaluated prior to coming in contact with you?

8. To your knowledge, are they medicated, and seen by a psychiatrist on a regular basis?
9. In your experience, how does the Probation Department treat mentally ill juveniles differently from non-mentally ill juveniles?

10. Do you interact with parents of mentally ill juveniles? If so, can you describe your experience in dealing with them?

11. Do you plan to continue working with juveniles? Would you like to see laws concerning treatment for mentally ill juveniles change? How so?

12. What Probation Department policies regarding mental illness would you like to see enacted?

13. Do you think that treatment for mentally ill juveniles is adequate and easily accessible?

14. Are you aware of any programs specifically designed and implemented for mentally ill juveniles in correctional facilities?

15. Have you had specific training in dealing with mentally ill juveniles, and if so can describe it?
APPENDIX B

INTERVIEW QUESTIONS FOR THE CLINICAL THERAPIST
1. What is your job title? Describe your everyday duties?

2. Do you work with mentally ill juveniles? If so, how long have you worked with them? Upon what evidence are you basing your conclusion that they are mentally ill?

3. Do you work with non-mentally ill juveniles as well?

4. Can you give me an example of a specific incident where you handled a mentally ill juvenile?

5. What types of differences have you observed in regards to the behavior of mentally ill juveniles versus non-mentally ill juveniles?

6. What types of treatment or counseling are you aware of that are available, and do you think that they are sufficient?

7. In general, have the juveniles you have seen been diagnosed prior to you making a diagnosis? If so, who makes the previous diagnosis?

8. How are these juveniles referred to you?

9. Do you reevaluate these juveniles after their first Juvenile Hall diagnosis?

10. After a mentally ill juvenile is detained how long does it take before you evaluate him or her?
11. In general, are mentally ill juveniles regularly medicated and how often do you see them?

12. In your experience, how are mentally ill juveniles treated differently from non-mentally ill juveniles?

13. Do you interact with parents of mentally ill juveniles? If so, can you describe your experience in dealing with them?

14. Do you plan to continue working with juveniles?

15. Within Juvenile Hall, what changes would you like to see implemented to improve the treatment of mentally ill juveniles?

16. Do you think that treatment for the mentally ill is adequate and easily accessible?

17. In your experience, do mentally ill juveniles feel comfortable talking to you about their illness and if so can you provide an example?

18. Including your educational background, what specific training have you had in dealing with mentally ill juveniles?
APPENDIX C

INTERVIEW QUESTIONS FOR THE SUPERIOR COURT JUDGE
1. What is your job title? Describe your everyday duties?

2. Do you work with mentally ill juveniles? If so, how long have you worked with them? Upon what evidence are you basing your conclusion that they are mentally ill?

3. Do you work with non-mentally ill juveniles as well?

4. In general, how many mentally ill juveniles do you see each month?

5. Can you give me an example of a specific incident where you handled a mentally ill juvenile?

6. Do you notice a difference in the types of crimes mentally ill juveniles commit as compared with non-mentally ill juveniles? If so, can you give some examples of those crimes?

7. What types of treatment are you aware of that are available, and do think that they are sufficient?

8. Do you think that the juvenile justice system is adequately prepared for mentally ill juveniles? Do you think that they receive treatment if they are incarcerated?
9. Are you aware of any programs specifically designed and implemented for mentally ill juveniles in the correctional facilities?

10. Do you treat mentally ill juveniles differently in your courtroom? If so, can you give me an example?

11. Have you ever had a mentally ill juvenile in your courtroom that had not committed a crime? If so, why was he in your courtroom? If not, have you known of any mentally ill juveniles that have been incarcerated without having committed a crime?

12. In your experience are mentally ill juveniles generally diagnosed with a mental illness before or after coming in contact with the juvenile justice system?

13. Do you plan to continue working with juveniles?

14. How would like to see laws concerning treatment for mentally ill juveniles change?

15. What Probation Department policies regarding mental illness would you like to see enacted?

16. Do you think that treatment for mentally ill juveniles is adequate and easily accessible?
17. Including your educational background, what specific training have you had in dealing with mentally ill juveniles?
APPENDIX D

DEMOGRAPHIC INFORMATION
1. Gender: Male ____ Female ____

2. Age: ___

3. Ethnicity (please check one): Caucasian ____ Hispanic ____ African American ____ Asian ____
   Other (please specify) ____________________________

4. Current position title: __________________________

5. Number of years in current position: ___

6. Number of years working with juveniles who have a mental illness: ___

7. Highest level of education completed (please check one): High School ____ Some College ____
   AA Degree ____ BA/BS Degree ____ MA/MS Degree ____
   Ph.D. ____ J.D. ____
REFERENCES


