

C012146 ABSTRACT: This chapter provides an overview of the issues confronting youth with mental health disorders who come in contact with the juvenile justice system. It is directed toward those who work with this population as a means of providing knowledge and improving the delivery of services to these youth.

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CHAPTER 1

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YOUTH WITH MENTAL HEALTH DISORDERS IN THE JUVENILE JUSTICE SYSTEM

“When did this detention facility become a psychiatric hospital? And why didn’t anyone tell me?”

A Juvenile Careworker

Michael is a 13-year-old male who has repeatedly been arrested for breaking into his school on the weekends. Michael was sent to a minimum-security group home. However, staff are considering transferring him to a more secure facility. The group home is not staff-intensive, and there is concern that the program does not have the resources necessary to manage Michael.

Staff members refer to Michael as the “needy one” because he constantly asks them the same questions over and over. Although the daily schedule remains unchanged, Michael continuously asks, “When is lunch?” “When is lunch?” “When is lunch?” Or he asks, “When do we get to go outside?” “Is it time to go outside?” “Is it my time to go outside yet?” Michael repeatedly misplaces his belongings and cannot keep track of his written assignments. He also forgets to complete the chores for which he is responsible. Michael bangs on

the door, hits the wall, jumps on his bed, or tries to disassemble his desk whenever the boys are placed in their rooms. The other youth in the group home find Michael immature, intrusive, and annoying. He continuously interrupts their conversations. And he becomes loud and demanding when they do not include him in activities. Most treatment in the facility takes place within a group format. But Michael has been unable to sit still for more than one-third of his 90-minute groups. This has resulted in numerous sanctions—including being removed from five of the seven treatment groups he is required to attend.

Kelvin is a 16-year-old male detained at a local juvenile detention center on assault charges. From the moment he arrived at the facility, he has been angry, hostile, and intimidating. He refuses to follow staff directions, stating that

detention staff are "working with the devil in a conspiracy against him." Nighttime is particularly troublesome for Kelvin. He becomes increasingly upset and refuses to go into his room when it is time for bed. Staff have had to physically restrain him twice. Kelvin has been confined to his room during much of his short stay at the facility, due to his hostile attitude and behaviors. Peers have told staff that Kelvin has been making suicidal statements about hanging himself on the weekend. Half of the unit staff think Kelvin is being manipulative and is just trying to get out of spending time in his room. The other half are worried that something is wrong with him and are fearful that he may truly be a danger to himself.

Amy is a 15-year-old female with a history of shoplifting and running away from home. She has been at a juvenile justice facility for girls for six months and has had intense mood changes much of that time. One minute Amy is happily engaged with staff and peers—often to the point of singing aloud and dancing in the dayroom. However, her mood can change quickly in response to negative interpersonal interactions. Amy often feels that the other girls are "ganging up" on her, and she accuses staff of "hating" her and trying to "ruin" her life. When she is upset, she isolates herself from others and superficially scratches her arm with staples or paper clips. Because Amy is verbal, articulate, and friendly much of the time, both staff and peers genuinely like to interact with her. They also try to be supportive when she is distressed. Nevertheless, Amy's intense mood changes are increasingly irritating everyone in the unit, and they are starting

to reduce their involvement with her. This is intensifying Amy's belief that no one likes her.

Marshall is a 17-year-old male committed to a state training school for a sexual offense. He has had little success in the program. After 12 weeks at the facility, he is still on the first level of a four-level token economy program. This has resulted in his having minimal access to privileges and incentives in comparison to his peers. Michael has been unable to accomplish the basic living tasks (e.g., keeping his room clean, making his bed, showering daily, arriving to meals on time) required to move to the next level of the token economy program. He has also had difficulty with his academic assignments in school and becomes disruptive when frustrated. Although Marshall is over 6 feet tall and weighs more than 240 pounds, his behavior is childlike and suggestive of a much younger youth. He is preoccupied with dinosaurs and enjoys repeatedly looking at the same picture book related to the prehistoric era. He has seen the movie *Jurassic Park* more than 12 times and takes pleasure in showing staff how he can recite his favorite lines from it. Marshall is typically easy-going and fairly quiet, but he can become oppositional and angry. He often does not follow staff directions. However, it is unclear as to whether he is doing this purposely or whether he does not understand what is expected of him. Marshall has had some brief successes in the program when staff have provided him with individualized attention and made minor modifications in his treatment plan. However, given the current staff-to-youth ratio, this is becoming increasingly difficult to provide.

Juvenile crime and violence is of national concern. The media continue to broadcast images of high profile cases of teenagers involved in murder, rape and burglary. Based on media portrayals, one could easily get the impression that most adolescents steal, carry weapons, and are involved in gang activity. Although the number of teenagers engaging in these activities is of concern, juvenile violence and crime have actually decreased since the mid-1990's (Snyder & Sickmund, 1999).

There is much variation among youth involved with the juvenile justice system. The majority of youth in the general population engage in some type of delinquent activity by the time they graduate from high school. However, most of these young people will not come into contact with juvenile justice. Of the minority of youth who do, approximately half of the adolescent males and three-quarters of the adolescent females will not return (Snyder & Sickmund, 1999). For the youth who continue their juvenile justice involvement, some will return a few times; others may become serious and chronic offenders. A small number of juveniles are responsible for the majority of serious and violent crimes.

Most people are unaware of the significant numbers of mentally ill youth involved with the juvenile justice system. Much of society views juvenile offenders as "bad kids in need of punishment." In truth, there are large numbers of juvenile offenders who are "ill kids in need of treatment." Anyone who has worked in a juvenile justice facility has come into contact with youth who have mental health disorders. Some of these youth are mildly disturbed, some of them significantly disturbed. Juvenile detention facilities and training schools—as well as juvenile justice ranches, camps, and group homes—across the nation, are filled with a sizable number of juveniles suffering from a variety of psychiatric disorders. These youths' ability to function in a juvenile justice setting may be compromised by:

- Severe attention and concentration problems
- Serious mood disorders
- Histories filled with traumatic events
- Thought processes that are unusual and bizarre
- Low intellectual functioning
- Issues related to using drugs and alcohol

Currently, the study of mentally ill juvenile offenders is in its infancy. We have little information regarding how mental health disorders and juvenile crime are related. And we have few solutions for effectively intervening with this complex and clinically complicated group of youth. This is unfortunate, given the high financial cost to society in relation to responding to juvenile criminal behavior (*e.g.*, law enforcement, juvenile courts, probation/parole, incarceration). This is in addition to the emotional and financial costs to youths' victims, as well as to youths' families. Only within recent years has attention been paid to the issue of juvenile offenders with mental health disorders, and it is long overdue. This chapter will provide an overview of this important issue.



JUVENILE OFFENDERS WITH MENTAL HEALTH DISORDERS

An increasing number of youth with mental health disorders continue to enter, and remain involved with, the juvenile justice system. The exact number of mentally ill juvenile offenders is currently unknown. However, it is clear that the rate of mental health disorders is higher among youth involved with juvenile justice versus their peers in the general population. Although no national statistics are currently available regarding the rate of mentally ill juvenile offenders, several small studies have attempted to obtain this information. Some of these studies have been conducted with incarcerated youth; some have been conducted with

juveniles under community supervision. Many of these studies have methodological problems (e.g., small numbers of youth, lack of comprehensive assessments, biased selection of youth interviewed), which limit the usefulness of the findings. Therefore, the following incidence rates should be viewed only as an estimate, until larger and more scientific investigations are conducted.

In addition, many of the studies evaluated incarcerated male juveniles. Thus, they may not generalize to juvenile offenders who have not been placed in residential juvenile justice facilities and/or to young female offenders. Most of the diagnostic categories listed below are associated with a range of percentages. This is because some of the studies used different assessment tools, assessed youth during different periods of juvenile justice involvement, and defined the same mental health disorder in a different manner. Not surprisingly, the various studies often found different rates of disorders among youth.

THE NEED IS GREAT FOR LARGE-SCALE STUDIES ON MENTAL HEALTH DISORDERS WITHIN THE JUVENILE JUSTICE SYSTEM IN ORDER TO DETERMINE HOW MANY YOUTH SUFFER FROM PSYCHIATRIC DISORDERS—AS WELL AS THE NATURE OF THEIR DISORDERS.

The need is great for large-scale studies on mental health disorders within the juvenile justice system in order to determine how many youth suffer from psychiatric disorders—as well as the nature of their disorders. Unfortunately, national studies are very expensive, time-consuming, and require a significant amount of coordination and collaboration between several systems (e.g., mental health and juvenile justice). Until these types of studies are conducted, the following information can only serve as a rough approximation concerning the rate of mental health disorders among juvenile offend-

ers. One should not rely upon the particular numbers in the table below, but should take to heart the general message represented by the numbers: youth involved with the juvenile justice system have significantly more mental health disorders than youth in the general population. And the mental health disorders from which these youth suffer are often serious and debilitating.

	General Population (in percentage)	Juvenile Justice
Mood Disorders	5-9	10-88
Attention Deficit Hyperactivity Disorder	3-7	2-76
Learning Disorders	4-9	36-53
Mental Retardation	1	13
Posttraumatic Stress Disorder	6	5-49
Conduct Disorder	1-10	32-100
Psychotic Disorders	.05-5	1-16
Substance Abuse/ Dependence	5.5-9	46-88

(American Psychiatric Association, 2000; Burrell & Warboys, 2000; Casey & Keilitz, 1990; Cauffman, Feldman, Waterman, & Steiner, 1998; Davis, Bean, Shumaker, & Stringer, 1991; Fergusson, Horwood, & Lynskey, 1993; Giaconia, Reinherz, Silverman, Bilge, Frost, & Cohen, 1995; Kashani, et al., 1987; Regier, et al., 1984; Smykla, & Willis, 1981; Steiner, Garcia, & Matthews, 1997; Timmons-Mitchell, et al., 1997; Ulloa, et al., 2000; Wasserman, et al., 2002)

Adolescents suffering from mental health disorders often suffer from more than one disorder at the same time. This is most commonly known as *co-morbidity* and is often the rule versus the exception among juvenile offenders. For example, it is not uncommon for youth to be simultaneously diagnosed with Conduct Disorder, a Learning Disorder and Major Depression or Attention-Deficit/Hyperactivity Disorder. Many of these youth suffer from a *co-occurring* substance abuse disorder as well. Issues related to co-morbidity and co-occurring disorders increase the complexity of screening, assessing, and intervening with this population of youth.

In addition to having a mental health disorder, a significant number of juvenile offenders have other issues that complicate their clinical picture. Suicide threats and actual suicide attempts are not uncommon among juvenile offenders and occur at much higher rates in comparison to youth in the general population. Cutting, carving, or burning themselves without the intent to die (self-injury/self-mutilation) is also not unusual; neither are extreme levels of irritability and aggression. Many juvenile offenders have experienced physical abuse, sexual abuse, and parental neglect. Their homes are often characterized by family conflict, low income, domestic violence, parental drug/alcohol use, and parental mental illness. Many juvenile offenders have been exposed to serious, sometimes life-threatening, traumatic events during their childhood and adolescent years. A considerable number of youth involved with juvenile justice have received some form of outpatient mental health treatment. Close to one-fifth have been hospitalized in inpatient psychiatric facilities, with some youth requiring multiple hospitalizations (Davis *et al.*, 1991).

A small subset of juvenile justice professionals remain unconvinced about the large numbers of juvenile offenders who are truly mentally ill. These individuals often assume that youths with mental health disorders reside in psychiatric hospitals, and youths who engage in delinquent/criminal behavior reside in juvenile justice facilities. This assumption is reasonable and consistent with common sense.

In truth, however, the population of youths residing within in-patient psychiatric hospitals and youth incarcerated within juvenile justice facilities often share more similarities than differences. One study compared the emotional and behavioral characteristics of youth in a state-operated psychiatric hospital for children and adolescents to youth admitted to a state juvenile justice facility. Youth were assessed on "Total Behavior Problems," which included separate measures of "Internalizing" problems (*e.g.*, sadness, anxiety, somaticizing) and "Exter-

nalizing" problems (*e.g.*, fighting, delinquency, swearing), as well as "Social Competence." Extreme behavior problems were noted for both groups, with no difference between the types of behavior problems exhibited by youth in the psychiatric hospital versus the juvenile justice facility (Cohen, *et al.*, 1990). In addition, more than one-third of the hospitalized youth had records of criminal charges or convictions. Race was the only factor that predicted the facility in which youth resided. African-American youth were more likely to be placed in the juvenile justice facility, and Caucasian youth were more likely to be placed in the psychiatric hospital. Although some professionals working in juvenile justice facilities may find these results difficult to believe, many would not be at all surprised. In fact, a number of juvenile justice professionals have recently reported feeling like they work on an inpatient psychiatric unit—given the emotional and behavioral difficulties among the juveniles in their care. This is particularly true among professionals working in facilities with female offenders.

It is unclear whether there has been an actual increase in the number of youth with mental health disorders becoming involved with juvenile justice. The perception of an increase may be due to juvenile justice professionals becoming more skillful at recognizing these youth. Recognition of juveniles with mental health disorders is definitely on the rise. More attention has been paid to issues related to mentally ill juvenile offenders during the past few years than has occurred in the past few decades. New mental health screening tools have been developed to better identify these youth. And staff training in identifying and managing juvenile offenders with mental health disorders has become available to juvenile justice professionals in all settings.

The perception of an increase in the number of youth with mental health disorders may also be due to the severity of mental health problems exhibited by juveniles currently entering the system. Working with severely

mentally ill juveniles can make it seem like there are more of them because these youth are particularly difficult to manage and control in juvenile justice settings — as well as on probation/parole. Although juvenile offenders with mental health disorders have always existed, the extreme nature of some of today's youths' emotional and behavioral problems is a new phenomenon. There appear to be an increasing number of mentally ill juveniles for whom standard mental health interventions (*e.g.*, psychotropic medication, effective behavior management, cognitive-behavioral therapy) have minimal effect. Usual management strategies that are effective with the majority of offenders can sometimes escalate the emotions and behaviors of some mentally ill youth. Further, some juvenile offenders with mental health disorders find negative sanctions rewarding (*e.g.*, room confinement, increased monitoring, removal from school).

IT IS ALSO LIKELY THAT THERE HAS BEEN AN ACTUAL INCREASE IN THE NUMBER OF MENTALLY ILL YOUTH BECOMING INVOLVED WITH JUVENILE JUSTICE.

In addition to the above factors, it is also likely that there has been an actual increase in the number of mentally ill youth becoming involved with juvenile justice. This rise may be due to a variety of factors. For example, recent changes in the mental health system have had considerable effects on juvenile justice. Accessing intensive quality mental health care has become increasingly difficult for adolescents. Across the country, many states report a significant reduction in the number of residential treatment options for youth with serious mental health disorders. Many adolescent treatment programs have closed or have restricted the number of beds available to mentally ill youth. Among the inpatient mental health treatment programs that remain in operation, many are

hesitant to accept youth with a criminal and/or aggressive history; some refuse outright to admit youth with these characteristics into their programs. Reasons for this cautiousness often include: needing to protect other youth (particularly those who are more vulnerable) in their programs from being victimized, and/or not possessing the level of resources necessary to manage youth with aggressive, criminal, and/or escape tendencies.

Even if juveniles are accepted into a residential mental health treatment program, they are not likely to remain there for a significant period of time. Years ago, youth with mental health disorders could remain in an inpatient treatment program for several months or even a year or more. Current changes in health care have resulted in much shorter lengths of stay. Most adolescents who are hospitalized in psychiatric facilities are released within a couple of weeks to several months.

Moreover, if juveniles become angry and aggressive while residing in a mental health treatment program, law enforcement may be contacted. This situation often results in youth being transferred to the juvenile justice system for assaultive behavior. Changes in health care have affected outpatient mental health services as well. Juvenile offenders with mental health disorders often encounter long waiting lists for treatment—even when their behavior is significantly problematic. In addition, limits have been placed on the types of mental health evaluations and interventions youth are eligible to receive. Even when juveniles are eligible for mental health services, the number of visits with mental health professionals is often limited.

When mentally ill youth are not appropriately evaluated and provided effective treatment services, their mental health is likely to deteriorate—resulting in a worsening of emotional and behavioral problems. When these youth are in the community (in our neighborhoods and schools), they often engage in behaviors or actions that bring them to the

attention of law enforcement. Sometimes these behaviors are minor; sometimes they are serious. These youths' troublesome behaviors may or may not be related to the juveniles' mental health disorder. Youth involved with the mental health system have little difficulty transferring into the juvenile justice system. Unfortunately, once youth are involved with the juvenile justice system, accessing the mental health system can be difficult. Unlike the mental health system, juvenile justice has little say regarding which youth it accepts or does not accept into its care. **The juvenile justice system has become the default placement for many youth with mental health disorders who are not receiving appropriate psychological and psychiatric treatment in the community.**

Certain patterns of drug and alcohol use may also play a role in the increasing numbers of mentally ill youth involved with juvenile justice. A considerable number of juvenile offenders are consuming alcohol and illegal drugs on a daily basis, which can result in harm to their developing brains. In addition, some youth are inhaling toxic chemicals ("huffing"), dipping marijuana cigarettes in formaldehyde, known more commonly as embalming fluid ("wet"), and regularly using substances with hallucinogenic properties (e.g., LSD, PCP, Ecstasy). These drugs can negatively affect youths' cognitive, emotional, and behavioral development.

The growing number of females entering the juvenile justice system also adds to the increasing number of juvenile offenders with mental health disorders. Female juvenile offenders typically demonstrate a higher need for mental health services than their male counterparts (Timmons-Mitchell, *et al.*, 1997).

The result of each of these above factors (and there are likely additional factors as well) is that the juvenile justice system continues to house and manage increasingly higher numbers of youth with mental health disorders. This situation would not be especially detrimental if:

- Juvenile justice facilities were equipped to handle the multitude of needs of mentally ill juveniles
 - Current juvenile justice policy were geared more toward treatment versus accountability and sanctions.
- Currently, this is not the case.



DIFFERENCES BETWEEN THE MENTAL HEALTH AND JUVENILE JUSTICE SYSTEMS

Juvenile justice facilities are not psychiatric hospitals, and should not be expected to function in that capacity. Psychiatric facilities typically employ a number of full-time licensed professionals formally trained in mental health (e.g., psychiatrists, psychologists, psychiatric nurses, social workers). Mental health professionals are usually on the premises daily for a significant period of time and are available by telephone when they are off-site. The average youth-to-line staff ratio on a typical mental health unit ranges from 4:1 to 6:1. The general philosophy of a mental health residential facility emphasizes treatment, and efforts are made to create a therapeutic environment. Youth are seen as having problems and in need of assistance. Intervention services are provided in a variety of modalities: individual, group and family. Trained mental health or medical professionals typically:

- Meet individually with youth on a regular basis
- Run daily or weekly treatment groups with four to eight youth at a time
- Meet with youths' families on several occasions

In residential mental health treatment programs, youth often have access to "talk" therapy, recreational therapy, and other modes of therapeutic services conducted by trained professionals. Psychotropic medication is routinely prescribed to youth who have emotional and/or behavioral problems, and medical

professionals monitor potential side effects of these medications. Most youth have their own rooms or are assigned one roommate. Mental health facilities typically have special rooms in which agitated or suicidal youth can safely spend time, calm themselves down, or recover from an upsetting incident. When applying for their job at a psychiatric facility, staff members consciously choose to work with children and adolescents with mental health disorders.

The mental health resources in a juvenile justice facility are typically different than those in a psychiatric facility. There are usually fewer professionals formally trained in mental health, and not all of them are licensed. Many of these professionals work on less than a full-time basis. Depending on the size of a particular juvenile justice facility, there may never be a mental health professional on-site. In these cases, juvenile justice professionals may need to:

- Manage acutely mentally ill youth without the help of a mental health professional
- Attempt to have a mental health professional drive to the facility to evaluate acutely mentally ill youth
- Transport acutely mentally ill youth to another location where a mental health professional is available (e.g., hospital emergency room, psychiatric hospital, juvenile justice facility with mental health resources)

Therapeutic modalities tend to be limited in justice facilities, and there is usually minimal access to individual or family therapy. Most treatment occurs in a group format, and many treatment groups are run by juvenile justice professionals with little to no training in mental health. Depending on the facility, some groups may include as many as 12 to 20 young offenders at a time. Recreational and art therapy services are becoming more common in juvenile justice facilities but are still only currently available at a minority of facilities. Although psychotropic medication is often prescribed to

youth in juvenile justice facilities, far fewer medical professionals are usually available to monitor the side effects of these medications. Additionally, due to the limited availability of medical personnel in some facilities (particularly small and/or rural facilities), juvenile justice professionals may be required to physically administer psychotropic medication to youth.

The environment of juvenile justice facilities is often different than that of mental health treatment programs. For example, in most facilities the youth-to-line staff ratio ranges anywhere from 8:1 to 40:1. Even when none of the youth are mentally ill, managing this number of *juvenile offenders* can be challenging for any one adult. Having one juvenile with mental health disorders can make supervision of a group this large significantly more difficult. Mentally ill youth can be disruptive to group dynamics due to symptoms of their mental health disorder (e.g., monopolizing group time, interrupting others, needing all attention on them, not having empathy for others, not understanding material that others understand, not respecting personal boundaries of others).

And most juvenile justice professionals report that one-third or more of the youth under their supervision display symptoms of mental illness! The use of strategic and effective interventions becomes less likely as the youth-to-line staff ratio increases. Although most facilities assign one or two youth to a room, some juvenile justice facilities place three or four youth in the same room. Some facilities do not have individual rooms at all; they are designed as dormitory-style settings. Youth may be required to sleep in one large room with 20, 40 or even 80 other youth. Not surprisingly, managing mentally ill juveniles in this type of setting can be particularly challenging. Most juvenile justice facilities have designated rooms in which an agitated or suicidal youth may reside. These rooms may be located on the youths' living unit or youth may need to be transferred to another unit (typically a more restrictive maximum security unit designed to manage juveniles with

severe behavior problems). However, some facilities do not have special rooms where a suicidal or aggressive youth can be placed. This can sometimes result in serious management problems when youth are experiencing significant distress.

Although rehabilitation and treatment are important goals of the juvenile justice system, safety and security issues must be held at the forefront. To protect the safety of youth and the staff, the behavior of juveniles is closely supervised, scrutinized, and evaluated. Room confinement may be relied upon—appropriately or inappropriately—as a sanction for negative behaviors. To protect the community at large, tall fences (sometimes with barbed wire) often surround the perimeter of juvenile facilities. And locks are placed on most, if not all, internal and external doors. Not surprisingly, the focus on custody, security and control of juvenile justice facilities can interfere with the development of a therapeutic environment. Although some juvenile justice programs are more “therapeutic” in nature, they are typically the exception rather than the rule. In addition, most individuals who seek employment within juvenile justice facilities do not consciously choose to work with mentally ill youth. In fact, many are completely surprised by the number of youth with mental health disorders under their supervision.

As stated earlier, large numbers of mentally ill youth continue to be detained or committed to short- and long-term juvenile justice facilities. Most juvenile justice professionals, however, receive little to no training about mental illness. In fact, most professionals who interact with juvenile offenders have not been formally trained in how to identify or effectively manage this complex population. These individuals quickly discover that standard programs and management strategies, which work with non-mentally ill juveniles, do not always work with juveniles who have mental health disorders (e.g., low IQ, psychotic thought processes, severe attention problems). Unfortunately, if

youth are not accurately recognized as having a mental illness, their inability to function successfully in a generic juvenile justice program can be viewed as a conscious—and purposeful—choice. This situation often results in sanctions for mentally ill youth and a delay in referral to appropriate intervention services.

Additionally, juvenile justice professionals are responsible for supervising a significant number of juveniles who are taking psychotropic medication. Most professionals in juvenile justice facilities have not received training in the various types of psychotropic medications prescribed to these youth. This type of training is critical because facility staff are often the first to observe behaviors that may indicate negative side effects of medication. Juvenile justice professionals also play a key role in referring youth to medical/mental health professionals for evaluation. Without proper training in how to identify juveniles with mental health disorders, staffs' ability to appropriately refer youth for proper assessment is severely compromised.

Moreover, for juvenile justice professionals without an understanding of mental illness, working with juvenile offenders who have mental health disorders can result in significant frustration, confusion, and exhaustion. The feelings of ineffectiveness often experienced by those trying to manage mentally ill juveniles can lead to staff burnout and hopelessness regarding particular youth. Once professionals have lost hope, they are less effective with juveniles. Gaining an understanding of how mental health disorders manifest in adolescents, particularly adolescent offenders, can help decrease this dynamic. Juvenile justice professionals can be more strategic when developing and implementing supervision and management strategies once they have a better understanding of the thinking and behavior of youth with mental health disorders.

Young offenders with mental health disorders also become frustrated and confused when juvenile justice professionals do not have knowledge or training related to mental illness.

For example, many juvenile justice professionals are trained to treat all youth equally in the name of fairness. However, this practice can put some youth with mental health disorders, particularly those with severe emotional and behavioral disorders, at a disadvantage. These juveniles may be putting forth as much effort as they possibly can within a facility. But they may still receive sanctions from staff because they do not have the capacity to meet the generic expectations of a particular living unit.

Juveniles with mental health disorders are typically aware when they are not progressing as quickly as their peers. Yet they often do not understand why they keep getting into trouble. When mentally ill youth have difficulty successfully meeting behavioral expectations, they may be denied certain privileges available to other juveniles. Mentally ill youth often interpret this situation as resulting from staff being “unfair,” and they may become angry and resentful. Furthermore, if youth are indeterminately sentenced to a facility (which typically entails release only after youth successfully complete a juvenile justice program), mentally ill juveniles can remain under juvenile justice supervision longer than nonmentally ill peers who have similar or less serious committing offenses. This lengthier confinement often has more to do with a lack of ability to complete a program the way it was initially designed (*i.e.*, for young offenders without mental health disorders) versus purposefully choosing not to comply with program requirements.

Differences clearly exist between the mental health and juvenile justice systems. An argument is neither being made that juvenile justice facilities should become “treatment” facilities, nor that mental health facilities should accept all juvenile offenders with mental health disorders. These options are not likely to occur, and they are not necessarily the most appropriate solutions. The population of youth residing in juvenile justice facilities is increasingly similar, if not almost the same, as the population of youth residing within mental health programs.

Therefore, additional mental health resources must be implemented within already-existing justice programs. At a minimum, these resources should include:

- The hiring/contracting of clinical staff
- Individualized need-focused interventions
- Staff training in mental health

Even if juvenile justice facilities had the resources to provide the number and types of services required of many mentally ill juvenile offenders, challenges still exist. One significant hurdle relates to the current philosophy of juvenile justice: changes over the past decade have resulted in the provision of treatment becoming less of a priority.



CHANGES IN THE JUVENILE JUSTICE SYSTEM

Our society's response to juvenile offending behavior has gone through many changes. Historically, youth were viewed as having the same cognitive, emotional, and moral processes as adults. So, youth and adults were treated in a similar fashion if they engaged in law-breaking behavior. Not until the early 19th century did society stop viewing children as miniature adults. They were then seen as individuals who had not yet fully developed all of their abilities. At this time, delinquent juveniles began to be placed in their own facilities, separate from adult offenders. By the beginning of the 20th century, specific courts were developed for juvenile offenders, with a primary goal of protecting them—particularly when their parents were unable to provide appropriate guardianship and care.

In contrast to the criminal justice system for adults, juvenile courts were fairly informal. Youth who engaged in delinquent behavior were recognized as needing treatment and appropriate supervision. Providing intervention and support for troubled youth was the primary mission of the juvenile justice system, versus punishment and discipline. Juvenile court

judges paid specific attention to an individual youth's particular issues and circumstances. It was the juveniles' needs that primarily determined the disposition plan, not the offense the youth committed.

By the 1960's there was concern that the juvenile justice system's mission to rehabilitate juveniles was not as effective as had been hoped. In addition, youth advocates were concerned that the rights of juveniles were being violated. For example, some youth were held in restrictive environments for significant periods of time to receive "treatment." In response to these concerns, juvenile courts became more formal, and youth were given many of the legal rights afforded to adults in the criminal justice system. However, there was also an emphasis on keeping youth who engaged in status offenses (*e.g.*, running away, truancy, uncontrollable behavior) out of the juvenile justice system. But by the 1980's, there was growing concern that crime and violence among young people was increasing and that the juvenile justice system was too lenient. Policy changes were made and several laws were modified, which resulted in the juvenile justice system more closely resembling the adult criminal justice system.

The 1990's were a period of significant toughening on criminal behavior committed by juveniles. It became easier to transfer youth from the juvenile justice system to the adult criminal justice system. Depending on the nature of their crime, some youth were automatically sent to the adult system, bypassing the juvenile system altogether. Presently, the juvenile justice system seems to have a different mission from its initial inception. Rather than primarily focusing on young offenders' circumstances and specific needs for treatment, much of the emphasis in today's juvenile justice system is directed toward:

- Holding youth accountable for their behavior
- Protecting the community

- Deterring future criminal behavior
- Providing restitution to those harmed
- Allocating sanctions consistent with the nature of youths' crime

(Snyder & Sickmund, 1999)

Although some states have moved toward emphasizing the development of youth competencies and skill-building, these objectives are usually secondary to those of accountability and sanctions. The challenge for the juvenile justice system today is to achieve a balance between offender accountability, community protection, appropriate sanctions, and the provision of appropriate evaluation and rehabilitation/treatment services. This is a tall order—particularly in the face of the significant numbers of youth involved with the system and the often-limited resources.

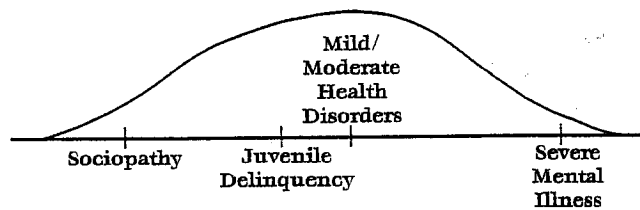


Figure 1. Normal curve of youth in a juvenile facility.



ISSUES of ACCOUNTABILITY

Mental illness is not an excuse for negative behavior within a juvenile justice facility. Juvenile offenders should be held accountable for their behavior, whether or not they suffer from a mental health disorder. However, juvenile offenders with psychiatric disorders should also receive appropriate mental health treatment. Juvenile offenders do not represent a homogeneous group of young people. Each youth has his or her own individual characteristics and circumstances. It can be helpful to view these youth on a normal curve (*see* Figure 1). At one end of the spectrum are the types of youth who would be described as "antisocial" or "sociopathic." They know exactly what they are doing when they commit criminal acts, are aware that these acts are against the law, and do them

anyway. They repeatedly violate the rights of others and experience little to no remorse about the damage they inflict upon other people or others' property. They are typically chronic and repeat offenders, and they have every intention of continuing their criminal behavior once released from a juvenile justice facility. Regardless of the type of juvenile justice programming, treatment, or intervention services they receive, these offenders will likely make minimal, if any, long-term positive behavior change. Ironically, these youth can move through juvenile programs fairly quickly because they know what they should say and do to give the impression they are "reforming." As young offenders meeting this description age, they are likely to

YOUTH WITH ATTENTION-DEFICIT/
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MORE IMPULSIVE THAN PEERS AND LESS
SKILLFUL IN PLANNING AHEAD.

eventually become involved with the adult criminal justice system. Although the media often portray this type of youth as the *typical* juvenile offender, such youth probably do not represent the majority of youth who come into contact with the juvenile justice system.

On the other end of the spectrum are those youth who are very seriously mentally ill. These juveniles may experience extremely psychotic thinking (*i.e.*, losing touch with reality), as well as exhibit unusual and bizarre behaviors. Some may have even been psychotic at the time that they committed their crime. Youth with severe mental health problems may repeatedly engage in dangerous, self-injurious/self-mutilating behavior or make recurrent serious suicide attempts. Or they may have substantial cognitive deficits, resulting in minimal understanding of their crimes, as well as what behaviors are expected of them during incarceration.

Juveniles who are severely mentally ill typically do not belong in the juvenile justice system and require intensive services from the

mental health system. These youth may have ended up in the juvenile justice system because their mental illness was not emphasized during court proceedings. Or if it was emphasized, it may have been hoped that juvenile justice would provide the youth with protection and intervention services. This is not unusual if previous mental health services had proven ineffective or unresponsive. Although a number of youth in the juvenile justice system fit this description, these youth are still likely to comprise only a minority of the juvenile offender population.

Between the two categories described above is a category containing youth who engage in various criminal acts and who also suffer from a mild-to-moderate mental health disorder (although their mental health can be severe at times). These youth are sometimes known as "double jeopardy" youth, due to having simultaneous problems related to both delinquency and mental illness. Many youth involved with the juvenile justice system know exactly what they are doing when they commit their crime and engage in the behavior anyway. For example, they are typically aware that stealing a car is wrong, selling drugs is against the law, assaulting someone could get them in trouble, and so forth. Many youth involved with the juvenile justice system, however, also suffer from disorders such as Attention-Deficit/Hyperactivity Disorder, Learning Disabilities, Major Depression and Mental Retardation. This category of youth is likely to be a much larger group than the other two categories of youth described above. Does this imply that young offenders who stole cars, stole the cars because they have Attention Deficit/Hyperactivity Disorder? Or that assaultive behavior is a direct result of youths' depression? Not necessarily. Delinquent behavior stems from a combination of a variety of different factors, including the individual characteristics of juveniles, their family, peers, school, community, and current laws. This does not mean that juvenile offenders' mental health disorders play no role in their criminal behavior. They may or

may not. For example, youth with Attention-Deficit/Hyperactivity Disorder are often more impulsive than peers and less skillful in planning ahead. These youth may not have seriously considered the consequences of their actions, or may not have planned their delinquent behavior well enough to avoid being caught.

In addition, adolescents who suffer from Major Depression are often extremely irritable, which can make it more likely that they will be involved in a physical altercation. Even if mental illness does play a role in their criminal behavior, it usually does not *cause* juveniles to break the law. Therefore, when they commit criminal offenses, juveniles should be held accountable (other than in extreme cases, which are rare). Having a mental health disorder is not an excuse to avoid taking responsibility for engaging in delinquent acts. A mental health disorder is also not a legitimate reason for youth to evade tasks or duties they view as undesirable once under juvenile justice supervision. If mentally ill juveniles engage in negative behaviors, they should receive consequences for their actions. However, in addition to issues of accountability, juvenile offenders with mental health disorders should be evaluated and provided appropriate intervention services. Addressing delinquent and mental health issues simultaneously is critical when supervising juvenile offenders with psychiatric disorders. These youth may require:

- Modifications in juvenile justice programming
- Additional intervention services
- Psychotropic medication

Moreover, substance abuse among juveniles is significantly related to both delinquent behavior and mental illness. Ignoring or dismissing any one of these key areas (delinquency, mental health, substance use) is likely to result in negative outcomes for juvenile offenders with mental health disorders, as well as for the juvenile justice system as a whole.



NATURE OR NURTURE

One of the most common questions asked by juvenile justice professionals relates to whether mental health disorders are associated more with nature or nurture. Is mental illness due to biological factors or environmental influences? New information about mental health disorders continues to be discovered, and the mental health field is constantly evolving. Yet the current consensus in the field indicates that the answer to the above question is "yes." Yes, biological factors play a role in many forms of mental illness and yes, environmental factors play a role in many forms of mental illness. For most juvenile offenders, their mental health disorders are likely related to an interaction between these two influences.

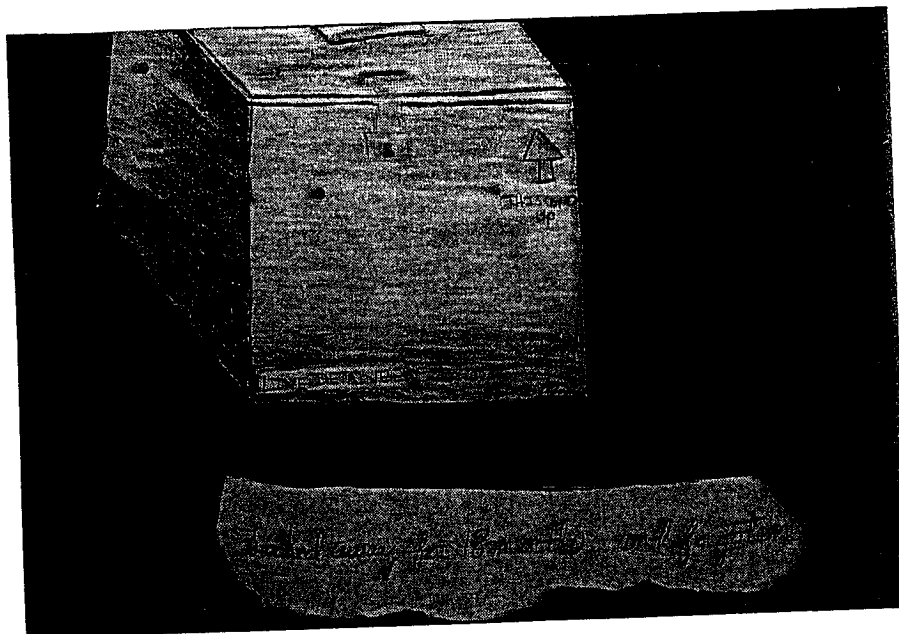
Presently, there is general agreement that many mental health disorders are the result of an interaction between individuals' predisposing vulnerabilities and the stressors they experience in their lives. This *diathesis-stress* model of illness has been applied to various medical disorders (*e.g.*, heart disease, cancer), as well as mental health disorders (*e.g.*, Major Depression, Bipolar Disorder, Schizophrenia). A "diathesis" refers to being vulnerable to, or having a predisposition to, develop a particular disorder. Psychopathology is thought to result when a diathesis interacts with stressful life events, unless there are ample protective factors or resources to offset it (Hakim-Larson & Essau, 1999). If an individual's parents or other close family members have heart disease or cancer, the individual is typically at risk to develop the same illness. Not all individuals with a family history of heart disease or cancer acquire those conditions. But they are more likely to than someone who does not have these medical disorders in their family. The same is true regarding mental health disorders such as the mood disorders and Schizophrenia. Youth whose relatives (*e.g.*, parents, grandparents, siblings, aunts, uncles,

cousins) have Bipolar Disorder or Schizophrenia are at higher risk of developing these disorders themselves in comparison to peers without these disorders in their family history.

The exact mechanism related to how mental illness is transmitted within families is not yet clear. But research has consistently shown that heredity plays a role in many of the major psychiatric disorders. For example, youth may inherit certain brain chemistry, particular ways of processing or organizing information, or an overly reactive nervous system. A significant number of juvenile offenders have parents and other close relatives who suffer from a variety of mental health disorders. Inheriting a biological predisposition to a psychiatric disorder makes it more *likely*, but it does not *guarantee*, that the youth will develop a similar mental health disorder as well.

Youth differ in their response to stressful life experiences. Some juvenile offenders can tolerate large amounts of stress and not develop a mental health disorder, even when they have inherited a biological vulnerability to do so. Other youth may develop mental health symptoms after exposure to only minor stressful experiences. In fact, juvenile justice professionals are often puzzled by youths' different responses to stress. Some juvenile offenders who have experienced horrific events can function at an adequate level. In contrast, other youth may appear fragile, and emotionally and/or behaviorally decompensate in response to much-less-severe stressors. The actual occurrence of a mental health disorder is likely the result of a combination of juveniles':

- Inherited biological or psychological vulnerabilities
- Environmental stressors



- Environmental supports
- Particular abilities and coping skills

Youth who have significant mental illness in their families, a variety of psychosocial stressors, and poor coping skills are likely at highest risk for mental illness. Many juvenile offenders fit into this category.

A considerable number of juvenile offenders lead lives filled with a variety of environmental stressors. Many are raised in single-parent homes and are from low socio-economic backgrounds. Their parents may have divorced or never married; some young offenders do not know their fathers. Juvenile offenders raised in one-parent or two-parent families have often witnessed domestic violence in their homes. Many juvenile offenders have been raised by a parent who is mentally ill and/or uses drugs and alcohol; this can result in a chaotic home, poor parental monitoring, and a lack of emotional support.

A significant number of these youth have been placed outside of their family homes: some have spent much of their childhood years in foster care, justice facilities, or moving from one relative's residence to another. In addition, many juvenile offenders have experienced physical abuse, sexual abuse and/or caregiver

neglect. Some of these youth have been exposed to a variety of toxins while in utero (*e.g.*, drugs, alcohol), and/or their mothers may not have received adequate prenatal or perinatal care. Many juvenile offenders live in neighborhoods inundated with crime, drugs, and violence. Walking down the streets of their community can be a dangerous endeavor. Moreover, many of these youth have experienced trauma to their heads while growing up (*e.g.*, abuse from adults, accidents, physical altercations with peers), with some to the point of being knocked unconscious. A number of juvenile offenders have also experienced the death of individuals close to them (*e.g.*, parents, siblings, friends, neighbors, relatives), with some of these deaths being violent in nature.

The effects of biological and environmental factors related to mental illness vary among the different mental health disorders, as well as among individuals. Biological influences may play a more significant role in youths' Mental Retardation or Attention-Deficit/Hyperactivity Disorder. Environmental influences may be more significant for youth suffering from Post-traumatic Stress Disorder.

Juvenile offenders are clearly at high risk for developing and manifesting a variety of mental health disorders because:

- Many have a high degree of mental illness among family members
- Many have been exposed to a significant number of environmental stressors

The Stress of Incarceration

The stress of incarceration can have a negative affect on the mental health of youthful offenders'—particularly if they have a biological predisposition to develop a mental health disorder. Some professionals working within juvenile justice facilities question the legitimacy of youths' mental health symptoms. This can be particularly true if these juveniles did not exhibit psychiatric symptoms during previous stays at a facility or if there is no report of the

youth exhibiting mental health symptoms in the community. Juvenile justice professionals often assume that youth are pretending to be mentally ill in order to receive certain benefits (*e.g.*, staff attention, medication, transfer to a psychiatric facility) because the symptoms seemed to have appeared out of nowhere. For example, youth may not exhibit depressive symptoms in the community, but they become suicidal soon after arriving at a justice facility. Youth with no history of self-injury/self-mutilation may begin cutting and carving their skin while incarcerated. Or youth with no history of mental health treatment may report hearing voices. When these behaviors appear without a prior history, juvenile justice professionals often become suspicious.

Incarceration can be an extremely stressful experience for young people—especially for youth arriving at a juvenile justice facility for the first time. Not knowing what to expect and fearing the worst can be frightening, particularly for youth of small stature and minimal criminal offending histories. The following is a sample of the many reasons why incarceration at a juvenile justice facility can be stressful for youth:

- Lack of freedom
- Minimal contact with friends and family
- Being told what to do and when to do it (*e.g.*, eating, showering, using the bathroom)
- Constantly interacting with bigger and tougher youths
- Being observed, supervised and monitored 24 hours a day by authority figures
- High degree of structure in all activities
- Numerous rules and being held accountable when rules are violated
- Having to participate in an academic setting for several hours a day
- Little to no choice regarding anything (*e.g.*, how they spend their time, with whom they spend their time)

- Conflicts with staff members (*e.g.*, different personality styles of staff, inconsistent management styles from shift to shift)
- Minimal access to being outside
- Little to no access to peers of the opposite sex
- Institutional food (*e.g.*, few to no choice in the type or amount of food they eat, unappetizing food, food they do not typically eat)
- Crowding
- Intimidation or threatening by peers
- No privacy (sometimes including having to shower with other youth)
- Being unaware of the legal process and what will next occur (*e.g.*, preliminary court dates, trial, sentencing, transfer to the adult criminal justice system)
- Uncertainty about when they will be released from a facility
- Uncertainty about where they will go after release (some youth are unable to return to their families or do not have families to which to return)
- Placement in isolation or seclusion rooms
- Having to discuss personal, and often painful, issues in front of strangers
- Having to go to bed several hours earlier than what youth is used to
- Having to wake up several hours earlier than youth is used to
- Minimal access to recreational activities or any type of physical activity
- Small sleeping rooms that contain minimal personal items (this can feel claustrophobic to some)
- Large sleeping rooms that are shared with a significant number of other offenders
- Undesirable peers as roommates (*e.g.*, a rival gang member, an aggressive or severely mentally ill youth, a sex offender)

- Confrontation regarding their offending behavior
- Fear of being raped
- Fear of being assaulted

A variety of factors related to incarceration can result in feelings of fear, anxiety, frustration, disappointment, or anger. These feelings are not uncommon among youth involved with the juvenile justice system, regardless of whether or not they are residing in a juvenile justice facility.

When juvenile offenders become distressed in the community, they usually engage in a variety of coping behaviors that are not available after incarceration. For example, when juvenile offenders become stressed or upset “on the outs,” they often smoke cigarettes or consume alcohol and other drugs. For some youth, becoming aggressive or engaging in delinquent behavior makes them feel better during difficult times. Others may engage in sexual behavior or run away when experiencing unpleasant emotions. These youth may not have exhibited classic mental health symptoms in the community because they were self-medicating with these behaviors/substances. A number of juvenile offenders deal with negative feelings by making suicide attempts or cutting or carving their skin in acts of self-injury/self-mutilation. Understandably, none of these behaviors is allowable in juvenile justice facilities and if engaged in, typically results in a variety of negative consequences and/or serious sanctions. Even youth who engage in socially appropriate coping behaviors in the community when distressed—talking with close friends or listening to their favorite music—soon find that they have minimal to no access to these behaviors after being locked up.

It can be extremely challenging for youth to experience the significant stressors associated with incarceration without being able to use their typical coping mechanisms. Although these coping strategies usually are not the most prosocial choices, they often helped these juve-

niles manage during significant times of stress, even if only temporarily. Helping young offenders acquire new and more socially appropriate ways of coping with negative emotions is one of the goals of the juvenile justice system. But until these new skills are developed (if they are ever developed), juvenile offenders often experience a variety of negative emotions during their stay in juvenile justice facilities. This does not mean that incarceration should be more pleasant for youths or that juvenile offenders should have access to destructive ways of managing their distress. However, adults working with incarcerated youth should not lose sight of the demanding and challenging conditions in which these youth are often placed. Further, youth with mental health disorders may have an even more difficult time adjusting to a juvenile justice environment than non-mentally ill peers. Youth who have a biological vulnerability to mental illness and/or those who have experienced mild mental health symptoms in the community may manifest significant mental health symptoms after incarceration. The combination of environmental stressors and the loss of typical coping strategies can result in:

- The emergence of mental health symptoms never before observed
- An exacerbation of psychiatric symptoms previously experienced
- Mild symptoms that may dissipate after youth have adjusted to the system

Juvenile justice professionals can lose sight of the stressors associated with residing in a juvenile justice facility—particularly if they have been working in this type of environment for a significant period of time. Both new and veteran staff should keep in mind that when psychiatric symptoms emerge or worsen among incarcerated youth, these symptoms are usually associated with the youth:

- Having difficulty living in a demanding environment
- Lacking the ability to cope versus avoiding responsibility

- Wanting to obtain special treatment/attention

Not all juvenile offenders find incarceration a stressful experience, however. For some youth, juvenile justice facilities offer a safe and protective environment in comparison to their lives in the community. A number of juvenile offenders feel closer to juvenile justice professionals than members of their own families. This is particularly true among youth who have been repeatedly incarcerated within the same facility. Experiences in a juvenile justice facility (e.g., particular staff members, structured environment, reinforcement of successes, school achievement) often provide these youth with a sense of competency, consistency and security they have never experienced. For this particular group of offenders, *release* from a juvenile justice facility may be the time when psychiatric symptoms begin to emerge or worsen.

The identification and management of juvenile offenders with mental health disorders is challenging due to the:

- Variation among youth in the juvenile justice system
- High numbers of mentally ill youth in the juvenile justice system
- Complexity of mentally ill youth in the juvenile justice system
- High numbers of youth using drugs and alcohol
- Present underlying philosophy of the juvenile justice system
- Limited mental health resources within the juvenile justice system
- Physical environment of most juvenile justice facilities
- Lack of mental health training for juvenile justice staff at all levels
- Effects of incarceration on mental health systems