

Warehoused: The Plight of 'Mad' Youths in the Juvenile Justice System

Danielle M. Shields*



Volume 8 – No. 1 – Spring 2011

** Danielle Shields is currently a graduate student in the Criminal Justice Department at the University of Nevada, Las Vegas.*

Abstract

On any given day, tens of thousands of youths are housed in juvenile correctional facilities and unfortunately, a staggering proportion of these individuals suffer from mental illness. Though juvenile justice facilities are largely ill-equipped to serve as surrogate mental institutions, they have assumed this role out of necessity, as there is a distinct lack of community treatment options for mentally ill juveniles. Faced with inadequate assessment and treatment practices once they are absorbed into the correctional system, many incarcerated mentally ill youth are simply warehoused. Drawing upon available research, this paper recounts the historical events that contributed to the current dearth of community treatment options for juveniles, describes the prevalence, treatment, and assessment of mental illness among juvenile detainees, and considers alternatives to the current policies that exist within the system.

About the Author

Danielle Shields is currently a graduate student in the Criminal Justice Department at the University of Nevada, Las Vegas. She will receive her Master of Arts in Criminal Justice on May 14, 2011 and plans to continue her education. Prior to entering graduate school, she received her Bachelor of Arts in Psychology in 2007 and her Bachelor of Arts in Criminal Justice in 2008 from UNLV. Her research interests are tied to various aspects of mental illness and the criminal justice system, corrections, policing, and public policy. Email: Shields2@gmail.com

Warehoused: The Plight of ‘Mad’ Youths in the Juvenile Justice System

Introduction

It's tragic. If you are a young person and mentally ill, you have to get arrested to receive treatment. (Coalition for Juvenile Justice, 2000, p.11).

It has been advanced by scholars for some time that the correctional system in the United States has begun to resemble a dumping ground for those that are looked down upon by society, such as the mentally disabled and disordered. In 1963, the Community Mental Health Center Act was passed with the goal of replacing lengthy and ineffective institutionalized treatment with short-term, community out-patient treatment and psychotropic medication (Etter, Birzer, & Fields, 2008). In a process that has since been dubbed deinstitutionalization, mental institutions released hundreds of thousands of patients, with many permanently shutting their doors. However, it soon became clear that this goal had been ill-conceived as communities failed to develop and provide tangible community treatment options for their mentally ill populations due to budgetary shortfalls. Unable to function in society, many of these individuals committed crimes and were absorbed into the correctional system, consequently creating a punitive substitution for facilities designed and equipped to treat the mentally ill; this shift from mental institutions to jails and prisons, accordingly, has been termed reinstitutionalization (Human Rights Watch, 2003). Rising up in the place of the mental institution and suitable community treatment, it has been surmised that “jails and juvenile justice facilities are the new asylums” (Moore, 2009, para. 6), many of which do little more than warehouse mentally ill juveniles.

Though the problem of reinstitutionalization has reached staggering proportions in both adult and juvenile correctional populations, it has particularly affected juvenile facilities. While approximately 15-20% of inmates currently residing in the adult correctional system are in need of treatment for mental disorders (Human Rights Watch, 2003; Magaletta, et al., 2009),

anywhere from 50-75% of incarcerated juveniles suffer from some form of mental illness (Shufelt & Cocozza, 2006; Teplin et al., 2002; Coalition for Juvenile Justice, 2000). The most common form of mental illness in juvenile detention facilities are disruptive behavior disorders (e.g., conduct disorder, oppositional defiant disorder), closely trailed by substance abuse disorders (Shufelt & Cocozza, 2006), consistent with the line of thought that the system pays the most attention to disorders that make juveniles burdensome to society. Anxiety (e.g. post-traumatic stress disorder) and mood disorders (e.g. depression and bipolar disorder) have also been reported among mentally ill juveniles (Shufelt & Cocozza, 2006). Serious forms of mental illness, such as schizophrenia, psychosis, and self-injurious behavior, have also been observed. Conservatively, it has been estimated that about 10% of juveniles in detainees have recently thought about suicide, with 10% of juveniles having attempted suicide over their lifetimes (Abram et al., 2008), while others have estimated that as many as 19% of juveniles in detention facilities are currently suicidal (Coalition of Juvenile Justice, 2000). Furthermore, many of the juveniles with mental disorders also have multiple diagnoses. As many as 79% of juveniles with mental illness meet the criteria for multiple disorders, with 60% displaying symptoms of three or more disorders (Shufelt & Cocozza, 2006); likewise, anywhere from approximately half (Teplin et al., 2005) to 60.8% (Shufelt & Cocozza, 2006) of mentally ill juveniles have coinciding substance abuse problems. Needless to say, there is a troubling saturation of mentally disturbed juveniles in the correctional system.

Despite the fact that so many mentally disordered juveniles are now a cog in the massive machine that is the United States correctional system, at best, the system falls short of dealing with what is now a pervasive problem; at worst, the system is woefully inadequate. In general, the training that correctional staff receives to deal with the mentally ill has been described as

deficient (Human Rights Watch, 2003; Coccozza & Skowrya, 2000). There is also an alarming and well-documented shortage of professionals that are trained to treat mental illness, both in communities and in criminal justice settings (e.g. Von Zielbauer & Plambeck, 2005). Juvenile correctional facilities in and of themselves are also rife with obstacles to treatment and as a result, juveniles are simply not given the psychological help that they desperately need. Though mental illness screening is recommended for all juveniles in the system upon their entry (Grisso & Underwood, 2003), during a 6 month timeframe, Teplin et al. (2002) found that only 15.4% of juveniles involved in the system were given inpatient treatment and that only 8.1% were treated in the community, falling astronomically short of the actual need for such services. It also appears that there is a racial bias that has translated into a barrier to treatment (Coalition for Juvenile Justice, 2000); empirical evidence has demonstrated that whites are significantly more likely to be treated than minorities (see Cauffman, 2004 for a review). Gender has also served as a barrier, as girls are also more likely to receive treatment than boys (Teplin et al., 2002).

Furthering the difficulties that are associated with access to proper screening and treatment by competent professionals, mentally ill juveniles experience unique challenges in regards to their transfer and release. For instance, it appears that being mentally ill can also expedite the entry of certain juveniles into the adult system, where they will likely further decline; notably youths that are closer to age 18, are minorities, have substance abuse problems, or are diagnosed with certain types of co-morbid disorders (e.g. disruptive behavior disorders) are more likely to be transferred (Washburn, et al., 2008). Once these juveniles are released from the care of the correctional system, it is likely that they are at increased risk to reoffend. McReynolds et al. (2010) demonstrated that juveniles with a mental disorder diagnosis were more likely to recidivate than their non-disordered counterparts. Specifically, individuals with

substance abuse problems, disruptive behavior disorders, and certain types of co-morbidity were more likely to reoffend, highlighting the need for increased programming once such individuals are released (McReynolds et al., 2010). However, there are also practices, such as planning a juvenile's discharge and reintegration into the community (Trupin et al., 2004), that can help ameliorate the effects of mental illness and increase the odds of success for mentally ill juveniles.

This paper will serve as an in-depth examination of the mentally disordered juveniles that come into contact with the correctional system and what they experience. First, the historical origins of deinstitutionalization, a policy that has created a ripple effect throughout the United States correctional system, will be examined as well as the resulting criminalization of mental illness; this will be done by examining the mental health adult system as a comparison point, as it is the destruction of this system that has left modern-day juveniles with few treatment options. Next, various aspects of mental health in the juvenile justice system will be examined, such as the prevalence of mental disorders, assessment procedures, and access to and the quality of mental health treatment in juvenile correctional facilities. Finally, proposed policy changes to increase the effectiveness of the system and better serve mentally ill juveniles will be briefly examined. In closing, the paper's findings will be synthesized and discussed along with recommendations to improve the situation for these offenders.

How We Got to Where We Are: Deinstitutionalization and Reinstitutionalization

States have depended on custodial [mental] hospitals and homes. Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release. The time has come for a bold new approach. – President John F. Kennedy, 1963 (Wooley & Peters, 2010, para. 7).

Since colonial times, America has been confronted with the question of how to effectively treat its mentally ill population. Though mental asylums had long been the standard response to the severely mentally ill, a paradigm shift emerged during World War II, and mental

health professionals started to examine the benefits of community health treatment over institutionalization. Psychiatrists witnessed the acute psychological stresses of war; despite preventative screening, soldiers began having nervous breakdowns and mental illness began appearing in previously healthy soldiers (Grob, 1994). As these problems became more common, battalions enlisted “first-aid psychiatry” to preemptively treat psychologically distressed soldiers with rest and in urgent cases, temporary psychotherapy (Grob, 1994, p. 194). After the war ended, preventative care was hailed by psychiatrists who argued that if people could be identified and treated before their psychological symptoms progressed into more severe forms of disorder, they could be treated in community outpatient settings rather than institutionally (Grob, 1994). Accordingly, a newfound dichotomy formed in the psychiatric community. The “traditional” medical model of psychiatry emphasized physical causes of mental illness as well as the classic mental institution. Conversely, the new wave, the increasingly popular Freudian psychodynamic perspective relied upon subjective psychoanalysis and tended to favor community treatment, a stance that would prove increasingly influential (Grob, 1994).

During the 40’s, in light of evolving healthcare, mental health enjoyed increased political attention and in the process was regarded as a serious social concern, as many medical hospitals began experiencing a surge in mentally ill patients, with some reporting that half of their beds were occupied by the mentally disordered (Grob, 1994). As a result, in 1946, President Truman signed the National Mental Health Act (NMHA) into law, which included several features:

...first, to support research relating to the cause, diagnosis, and treatment of psychiatric disorders; second, to train mental health personnel by providing individual fellowships and institutional grants; and third, to award grants to states to assist in the establishment of clinics and treatment centers and to fund demonstration studies dealing with the prevention, diagnosis, and treatment of neuropsychiatric disorders (Grob, 1994, p. 210).

With the passage of the NMHA, the scales began to tip in favor of community health treatment. The NMHA provided monetary support to achieve its goals, though it was expressed that these funds would not be used for the purpose of supporting traditional mental institutions (Grob, 1994). Required by the NMHA, the National Advisory Mental Health Council (NAMHC) was created in order to provide guidance regarding mental illness; eventually, the NAMHC established National Institute of Mental Health (NIMH) to research effective psychological practices and supply information on mental disorders, among other functions (Grob, 1994). The NIMH began to advocate decline of the mental institution, as they used their assets to convince states to establish other methods to treat patients, such as outpatient clinics. The NIMH's encouragement permeated the psychiatric community, and preventative community treatment centers arose in nearly every state, totaling 1,300 by the mid-50's (Grob, 1994). Likewise, advances were accomplished that made community treatment theoretically obtainable, such as psychotropic medications and psychotherapy, which ostensibly assured that the mentally ill could function outside of a mental institution (Isaac & Armat, 1990).

Despite the theoretical zeal that surrounded the widespread implementation of prevention and community care, in practice, there was a general lack of research-based evaluation of these claims. By the mid 50's, the NAMHC became more aware of the problems associated with evaluating community treatment, noting the "vagueness surrounding the whole problem of community mental health" and was unsure of how to even properly define the concept of success (Grob, 1994, p. 215). In 1955, the NIMH appointed the Joint Commission on Mental Illness and Health (JCMI) to suggest mental health policy changes (Isaac & Armat, 1990). Contrary to the wishes of some, the JCMI recommended that mental hospitals be revamped. Ideally, patients would be treated in regular hospital settings, and if needed, would go to reduced size, specialized

treatment centers (Isaac & Armat, 1990). Notably, the JCMH recommended that community care *complement*, not replace, mental institutions. It also did not share the increasingly popular view of preventative care, questioning the science behind it (Isaac & Armat, 1990, p.75). Predictably, the report (ironically titled *Action for Mental Health*) was all but discarded by the NIMH, which had already made up its mind about preventative care (Isaac & Armat, 1990).

In 1960, President Kennedy, who had been personally touched by the inadequacies of mental health treatment after his sister was incapacitated by a lobotomy, became interested in reforming the system. To determine what type of reform was needed, he appointed a “Secretary’s Committee” made of up several officials and the NIMH to examine the JCMH’s report (Isaac & Armat, 1990). The Committee determined, after ignoring the bulk of the JCMH’s findings, that prevention should be the new face of mental health treatment, with one center per 50,000 people (Isaac & Armat, 1990). In a statement to congress, President Kennedy praised prevention:

Here, more than in any other area, ‘an ounce of prevention is better than a pound of cure’. For prevention is far more desirable for all concerned. It is far more economical and it is far more likely to be successful (Isaac & Armat, 1990, p. 77).

Prevention and community treatment was an attractive political option for two main reasons. First, critics had long attacked the deplorable conditions that existed in mental institutions; one report aptly described mental hospitals as “inferior” and running “below humanitarian and good professional standards” (Grob, 1994, p. 171). Second, in addition to concerns about the quality of care in mental institutions, economics were also a major driving force behind their elimination; prevention and community care was simply a much less expensive alternative. President Kennedy estimated that approximately \$1.8 billion was spent annually on the institutional treatment of the mentally ill (Woolley & Peters, 2010). Mental

institutions, simply put, were a budgetary drain. Yet, the JCMI's report had recommended that funding for mental health be *tripled* over the next decade, much to the dismay of congress (Isaac & Armat, 1990).

Despite the red flags stemming from a lack of research on its true effectiveness, the ideals of deinstitutionalization would be legislated into reality. President Kennedy pledged to congress:

Reliance on the cold mercy of the custodial institution will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away (Wooley & Peters, 2010, para. 12).

Congress was sold on the idea of eliminating institutional populations in lieu of any actual evidence that the goal of prevention was doable (Isaac & Armat, 1990). 1963, the Community Mental Health Center Act was officially written into law; congress allocated \$150 million to construct community centers and soon after, \$735 million for hiring staff (Isaac & Armat, 1990). Soon after the law's passage, two dire consequences began to emerge (Isaac & Armat, 1990). First, severely, chronically ill patients were essentially left out in the cold (literally, as it would turn out later). Second, there was a general lack of coordination with existing mental hospitals in order to get their existing patients into community health treatment, as the goal was simply to eliminate the hospitals. Nobody considered what would happen once the mentally ill were released back into the "warm embrace" of the community, as they did not qualify for disability services, and many were without families to take them in. Concurrently, an anti-psychiatry movement materialized, placing the final nail in the coffin of traditional institutional treatment. Inspired by counterculture, which embraced rebelling against societal norms, mental illness was perceived as an extension of this rebellion; society and psychiatrists

were the true conception of insanity (Isaac & Armat, 1990). These ideas would seep into public policy, since if mental illness wasn't real, it didn't *need* funding.

Soon after the proverbial axe had dropped on the mental institution, the true reality of community mental health began to set in. Though it had been expected that community health centers would serve as a panacea for mental illness and a replacement for institutions, this simply was not the case. Primarily, centers offered psychotherapy (commonly psychodynamic), with approximately a million sessions a year (Isaac & Armat, 1990). One official commented the centers focused on “people who had interesting dreams” rather than the chronically ill (Isaac & Armat, p. 96). A mere 10% of severely ill patients were receiving treatment and many of these individuals ended up on the street (Isaac & Armat, 1990). Additionally, people were still being transferred to hospitals, and there was a distinct lack of hospital aftercare that was not addressed until 1975. By 1971, the institutional population had been slashed to 308,000 (in 1957, it was 557,000) despite a sharp increase in hospital admissions (Grob, 1994; Isaac & Armat, 1990). As funding began to disappear from community health centers, staff members followed suit; half of staff psychiatrists left from 1970-75 (Isaac & Armat, 1990). Meanwhile, the picture was similarly bleak in juvenile correctional institutions; a survey conducted in 1967 found that the majority (58%) of juvenile facilities lacked therapeutic options and casework services and alternative “forestry camps” were also lacking in way of counseling (Roberts, 2004).

Over the next few decades, the system continued to deteriorate. Institutions had markedly downsized to only 119,000 beds by 1986 and the time spent in these beds significantly decreased to a median of 28 days (Grob, 1994). Community centers were also scarce; in 1978, there were only 600 compared to the 2,000 that had been originally envisioned (Isaac & Armat, 1990). Individuals that would have previously been housed in mental institutions were simply

shifted to the psychiatric wards of general hospitals, who, by 1983, had become the front-runner for treating inpatients (Grob, 1994). The system was simply without the resources to properly care for the mentally ill. Consequently, the mentally ill became criminalized, as they were unable to function in their communities or seek effective, long-term treatment. Prior to deinstitutionalization, the mentally ill were arrested and convicted at normal rates; afterward, however, evidence indicates that mentally ill individuals were arrested more frequently than their peers, particularly for crimes of a violent nature and other offenses stemming from a general lack of self-control (see Isaac & Armat, 1990, for a review). Mentally ill individuals with substance abuse problems were also more likely to commit violent acts and be arrested (Isaac & Armat, 1990). These trends have unquestionably endured in the juvenile population of today, as many of these individuals struggle with substance abuse and behavioral problems (Shufelt & Coccozza, 2006).

The deconstruction of the mental health system for adults symbiotically affected mentally ill juveniles. Yet, despite the dwindling amount of psychiatric beds, admissions for juveniles to mental institutions increased by four times between 1980 and 1984 alone (Weithorn, 1988). During the 1990's, the criminalization of mentally ill juveniles began to take a pronounced turn, worsening an already severe problem. In the wake of the crack epidemic and the sensational media coverage that constructed the image of the violent and callous juvenile "superpredator" (Innes, 1997; Muschert, G. W., 2007), the public feared the ostensibly exploding juvenile crime rate (Vidal & Skeem, 2007). As a result, the system shifted away from rehabilitation toward the "tough on crime" movement and the warehousing of juveniles who desperately needed psychotherapy. Ultimately, children were labeled as violent and uncontrollable rather than mentally ill; Feinstein et al. (1998) found that in one detention facility, only 16.7% of juveniles

were being treated for mental health problems prior to their incarceration; further, in some facilities, a staggering 80% of juveniles were diagnosed with conduct disorder and the overall rate of mental illness was at least two to four times greater than in adult facilities (Otto et al., 1992). Even if juveniles did qualify for institutional services, 90% of the mental hospital beds had been eliminated as of 2000 (Gottschalk, 2009). Furthermore, mental hospitals typically do not accept violent individuals, essentially leaving them to the care correctional system that will inevitably absorb them.

The Current State of Mentally Ill Juveniles in the Criminal Justice System

The teenager in the padded smock sat in his solitary confinement cell here in [his] state's most secure juvenile prison and screamed obscenities. The youth, Donald, a 16-year-old, his eyes glassy from lack of sleep and a daily regimen of mood stabilizers, was serving a minimum of six months for breaking and entering. Although he had received diagnoses for psychiatric illnesses, including bipolar disorder, a judge decided that Donald would get better care in the state correctional system than he could get anywhere in his county (Moore, 2009, para. 1).

Following the gradual dissolution of the mental institution and the astronomical failure of community treatment, mentally ill juveniles today are now left with two less than desirable supervisory treatment options: their families or their local correctional system, which now serves as the de facto mental health system in the United States (Slate & Johnson, 2008). At least 10% of juveniles in the United States suffer from a serious mental disorder (National Alliance on Mental Illness, 2010) and many are left in the care of family, who assume the role of makeshift psychiatric staff (Isaac & Armat, 1990). There are few institutional options and such options are cost prohibitive, as the average psychiatric hospital stay for a juveniles ranges from ten to eleven days and costs upwards of \$1,000 per day (as cited in Sheidow et al., 2004; Burns, 1991; Chabra, 1999). Consequently, the juvenile justice system has become responsible for the subset of children who, as a product of mental illness, become involved in illegal activity. As of 2008, approximately 92,845 juveniles reside in detention facilities (Bureau of Justice Statistics,

2010). Based on current prevalence estimates of mental illness among incarcerated juveniles ranging from 50 to 75% (Shufelt & Coccozza, 2006), anywhere from 46,423 to 69,633 mentally ill juveniles are currently in custody, a figure that is particularly striking, as in 2005, 1.6 million juveniles were processed via the juvenile court system (Elrod & Ryder, 2011).

Prevalence Rates

Several different scholars have each studied the dispersion of mental disorders among incarcerated juveniles and have come to varying conclusions. A recent estimate of prevalence among juveniles in detention facilities was conducted by Shufelt and Coccozza (2006). The authors sampled 1,400 youth from 29 facilities and programs in Texas, Louisiana, and Washington. Largely consistent with previous estimates since 2002, 70.4% of these youths were mentally disordered (this rate drops to 66.3% when conduct disorder is removed). Overall, nearly half of youths displayed behavioral disorders (46.5%) and met the criteria for a substance abuse disorder (46.2%). Anxiety disorders (e.g. general anxiety disorder, separation anxiety, and obsessive compulsive disorder) were observed in approximately a third (34.4%) of juveniles, while 18.3% had a mood disorder (e.g. major depressive disorder, bipolar disorder). The majority (60.8%) of mentally ill youths also had a co-occurring substance abuse disorder.

Moreover, the prevalence of more severe forms of mental illness is troubling. Serious forms of mental disorder (i.e. those requiring immediate and intensive treatment, such as major depression, manic episodes, and psychosis) accounted for nearly a third of participants (27%), exceeding previous estimates of 20% (Shufelt & Coccozza, 2006; Coccozza & Skowyra, 2000). Anywhere from 1 to 6 percent of juvenile detainees suffer from schizophrenia or other psychotic forms of illness (CJJ, 2000). A recent meta-analysis conducted by Fazel et al. (2008) determined that the prevalence of psychosis was 10 times higher in juvenile detention facilities than in the

general population, totaling at 3%. These rates give weight to the frightening situation that has become commonplace in juvenile detention facilities, where a significant number of juveniles exhibit disorders, some of which are especially serious. This is particularly distressing, as comparatively, only 20% of juveniles in the general population display some type of psychopathology (Merikangas et al., 2010).

Research has generally supported the notion of gender-based differences in prevalence rates of mental illness among adults and juveniles. As a preliminary estimate of such differences, Teplin, Abram, and McClelland (2002), sampled 1,829 youth from Cook County and assessed them using the Diagnostic Interview Schedule for Children, which focuses on the past 6 months of symptomology. The authors found that females were slightly more likely to be diagnosed with a disorder compared to males (66% vs. 74%) and that their overall odds of having any mental disorder were elevated. Females were also more likely to be diagnosed with anxiety disorders (31% vs. 21%) and mood disorders (28% vs. 19%). Among females, older juveniles were less likely to be diagnosed with conduct disorder than younger juveniles (in general, older children were more likely to be diagnosed than younger children). However, Shufelt and Cocozza's (2006) subsequent estimate yielded an even greater gap between boys and girls; it was found that 81% of females had at least one disorder compared to 66.8% of males. This relationship extended to nearly every sub-type of mental disorders, mood disorders (29.2% of females vs. 14.3% of males), disruptive behavior disorders (51.3% vs. 44.9%), substance abuse disorders (55.1% vs. 43.2%), and in particular, anxiety disorders (56% vs. 26.4%) (Shufelt & Cocozza, 2006).

In order to replicate the findings of Teplin et al. (2002), Karnik et al. (2009) assessed gender differences in mental disorders and substance abuse problems among 790 juveniles

incarcerated in California. Participants had been detained for approximately 9 months and were evaluated using a clinical interview and DSM criteria. Even when disruptive behavior disorders (which tend to account for a significant amount of mental illness) were controlled in the subsequent analysis, the vast majority of youths displayed psychiatric disorders (88% of males and 92% of females) and substance abuse problems (86% of males and 84% of females). Some significant differences were observed by gender in relationship to specific types of mental illness. Females, overall, were more likely to suffer from a mental disorder and were significantly more likely to have anxiety disorders (55% of females versus 26% of males) and mood disorders (29% versus 8%). In terms of substance abuse, males were more likely to use marijuana (19% for males versus 11% for females) and become addicted to it (32% versus 24%) while females were more likely to use stimulants (25% versus 44%). These findings suggest that psychiatric prevalence rates by gender should be considered in both assessment and treatment practices to better target the specific needs of incarcerated youths rather than a one-size-fits-all approach.

In addition to gender differences among detainees, co-morbidity, otherwise known as the occurrence of one or more mental disorders within the same person, is also a significant problem within the juvenile justice system, amplifying both the difficulty of treating such youths and their prognosis. In order to quantify this issue, Abram et al. (2003) examined a sample of 1829 juveniles¹ and diagnostically interviewed them. It was found that females were more likely to display co-morbidity (33.6 % versus 24.2% of males) for mood disorders, anxiety disorders, ADHD, and alcohol, marijuana, and other substance abuse problems (including behavior

¹ Abram et al., 2003, Teplin et al., 2002, and Teplin et al. 2005 conducted their analyses using the same sample, as these juveniles were participating in the Northwestern Juvenile Project, a 3 year effort to examine different facets of mentally ill juveniles in the correctional system.

disorders, these estimates increase to 56.5% and 45.9%). Disturbingly, among youths that were diagnosed with substance abuse disorders, a significant amount (approximately 30% of females and 20% of males) were concurrently seriously mentally disordered (e.g. psychosis, manic episodes, and major depressive episodes). Interestingly, those diagnosed with only one disorder were somewhat uncommon (17.3% of females, 20.4% of males). Based on available research, not only are females more likely to experience a mental illness in the first place, but they are more likely to have multiple illnesses, underscoring the need to provide them with particularly intensive treatment.

Recent estimates of co-morbidity, however, have yielded an even greater concentration of multiple mental illnesses among juveniles in the justice system. For example, Shufelt and Coccozza (2006) observed a co-morbidity rate of 79%. Additionally, they found that, alarmingly, 60% of the juveniles in their sample were classified as having 3 or more mental illnesses (Shufelt & Coccozza, 2006). Karnik et al. (2009) found similarly high co-morbidity rates of (86% for females and 85% for males) in terms of substance abuse, behavioral disorders, and mental disorders. Even when considering the conservative end of such findings, it is clear that these youth are relatively common in the juvenile justice system. Additionally, these individuals may have a poorer prognosis or be suffering from particularly severe disorders (Abram et al., 2003) and as a result, may have unique service needs compared to youth with only one diagnosis. Thus, juveniles with co-morbidity should be afforded treatment that accounts for their increased needs.

Screening and Assessment Practices

We don't pretend to be a treatment center; this is a detention home. We do not have medical staff here 24/7, much less mental health staff. We're holding these children, and they're not being helped by being where they are (Bolante, R., 2006, para. 7).

In order to appreciate the current statistics on the incidence of mental illness in detention facilities, it is crucial to examine the assessment procedures that juveniles experience when they enter into the system; such procedures are a critical step in gauging more accurate prevalence estimates, and more importantly, getting juveniles the treatment that they need. In a policy brief for the National Center for Mental Health and Juvenile Justice, Grisso and Underwood (2003) described the fundamental aspects that are involved in assessment and screening as well as recommendations to effectively carry out these practices. Though the terms are often used interchangeably, screening and assessment are actually distinct from one another; while screening refers to a brief, triage-like process to detect emergent issues that may need further examination, assessment refers to a more thorough process, often in which potential problems found a screening are more carefully examined (Grisso and Underwood, 2003). Thus, it is particularly important to both screen, and when applicable, assess juveniles who enter into the correctional system. Grisso and Underwood (2003) recommend that juveniles be screened as soon as they come into contact with the juvenile justice system (and be re-screened at periodic intervals). If screening identifies a potential problem, then youths should be fully assessed with reliable, valid instruments, preferably by a professional who possesses expertise (Grisso and Underwood, 2003).

However, there is evidence that at the very least, there are systemic gaps in the screening and assessment of mentally ill juveniles. According to a recent review of practices of juvenile justice facilities and their dealings with mentally ill juveniles, though facilities are screening juveniles at extremely high rates for emergent medical problems (97%) or substance use (91%),

they are less likely to screen in areas of mental health (as cited in Desai, et al., 2006; OJJDP, 1994; Goldstrom et al., 2000; National Commission on Correctional Healthcare, 1994). Specifically, 73% of juvenile detainees were generally screened for a history of mental health problems and 57% were screened regarding their treatment history (as cited in Desai, et al., 2006; OJJDP, 1994; Goldstrom et al., 2000; NCCH, 1994). Only 61% of juveniles received a more in-depth mental health assessment, while extensive assessments for drug abuse (78%) and alcohol use (75%) were more commonplace (as cited in Desai, et al., 2006; OJJDP, 1994; Goldstrom et al., 2000; NCCH, 1994). Drawing from available evidence on the prevalence rates of mental illness within this population, the amount of assessments for detained juveniles should be significantly greater and likely means that screening processes may not be picking up markers for current mental illnesses that would warrant an assessment. Unfortunately, assessments are costly and often require a clinical psychologist or psychiatrist, and having an accurate diagnostic process is useless if juveniles are not subsequently treated.

Treatment Quality and Access

... ASB had been severely abused since he was a toddler until he was adopted at age 4 years. But his adoptive parents ultimately severed their relationship with him after he complied with a hallucinatory command to cut a cat's throat with a chainsaw. Remanded to the Mental Health Unit (MHU) of the Ohio River Valley Juvenile Correctional Facility in Franklin Furnace, OH, USA, ASB was diagnosed with bipolar disorder and attention deficit hyperactivity disorder. He had an IQ of 70, suggestive of mild mental retardation... The staff at the MHU did not have the training to work with someone with his cognitive and intellectual limitations, and his chart contains no mention of any therapeutic interventions (MacReady, N., 2009, p. 601).

As research has indicated that mentally ill juveniles tend to recidivate at higher rates than their non-disordered peers (McReynolds, et al., 2010), providing access to quality treatment, whether it is provided by the institution or in the community, is imperative. However, it is an unfortunate reality that treatment is delayed in most juvenile institutions and some juveniles are

placed in such institutions not because they are charged with a crime, but because they simply do not have any other treatment options. A report by the U. S. House of Representatives (2004) revealed that of 524 juvenile detention facilities, 66% admit that they retain juveniles that are awaiting outside mental health services, while 71 facilities reported holding such juveniles without any charges (117 report holding children as young as 10). In true testament as to the failure of viable community options, in a 6 month period alone, approximately 15,000 juveniles were detained while waiting on mental health services, and on average, were held 6 days longer than other juveniles. Many facilities are aware of their shortcomings in providing short-term care to mentally ill individuals seeking community treatment; 27% of such facilities rated themselves as poor or simply unequipped to deal with the mentally ill and 54% report staff are poorly trained or not trained at all to deal with the mentally ill. In 1998, it was found that 39 % of facilities are still not served by a psychologist, and an additional 30% do not have any other type of mental health professional (as cited in Desai, et al., 2006; Goldstrom, et al., 2000). Regardless of their preparedness, a 2005 estimate indicates that more than 408,400 youth are held in short-term detention facilities every year, a number that has continued to rise (Siegel & Welsh, 2009).

Other estimates of access to treatment support the image of a pronounced lack of mental health treatment within the juvenile justice system. Teplin et al. (2005) sought to determine how many juveniles needed services and if those needs were being met up to 6 months (or by the time their case was tried at disposition) after their initial incarceration. Juveniles were diagnostically assessed for a formal diagnosis with a clinical interview and were assessed for global functioning impairment. Of the 303 youth who needed treatment (defined as those with psychosis, mania, or a major depressive episode and impaired functioning), only 15.4% received treatment in their

respective facility and an abysmal 8.1% received treatment in their community, while 10.9% of those who (according to their diagnostic profile) did not need treatment, received it anyway (Teplin et al., 2005). Many more female youth were screened as mentally ill during initial processing and subsequently treated compared to boys. It was also observed that membership in the following sub-groups increased a juvenile's likelihood of being treated: non-Hispanic whites, younger detainees, individuals processed as juveniles rather than adults, and juveniles with a past history of treatment (Teplin et al., 2005). Even though it is a positive step that girls are being treated at higher rates (though still undertreated), other groups, namely minority males, still remain vastly underserved.

There is evidence that indicates racial disparities in the amount of juveniles that receive treatment, which is problematic, as racial minorities constitute the majority of those housed in juvenile detention facilities (Teplin et al., 2005; Sickmund et al., 2005). To empirically examine that relationship between race, treatment needs, and the fulfillment of such needs, Rawal et al. (2004) sampled 473 juveniles from three counties in Illinois and compared them by group membership (Caucasians vs. African Americans vs. Hispanics). The records of each juvenile were examined and rated using the Child Severity of Psychiatric Illness, a 4 point rating scale that accounts for several indicators of mental illness (e.g. symptoms, overall functioning, and present risk factors). In terms of mental health needs, African Americans scored the highest. Yet, compared to Caucasians, African Americans were significantly less likely to be currently receiving treatment, have prior treatment history, or have ever been in treatment, while Hispanics were the most undertreated of all. Teplin et al. (2005) supports this assertion, as in their sample, the proportion of treatment among older (aged 14-18 years) male African Americans was only 7.3%. In light of their relative psychological vulnerability and the fact that minorities are more

likely to be indigent, it is likely that they also do not have access to proper care in their communities (Rawal et al., 2004). Therefore, it is crucial to increase services for this population.

Suicide in Juvenile Detention Facilities

Ellis Fallen battled psychosis for months before he killed himself at age 15. Tabatha Brendle, also 15 when she died, first attempted suicide when she was 5. David Ryther, 14, tried to end his life at least three times before completing that last desperate act by hanging himself with his bedsheet. These young deaths are all the more tragic because they occurred in detention or at state-run correctional facilities, where the teens were serving time for such crimes as riding in a stolen car, hitting a group home staff member, or breaking and entering (Twedt, S., 2001, para. 1).

Juvenile detention facilities, by virtue of the population they house and the conditions of confinement, will inevitably deal with suicide or suicidal behaviors. It has been estimated that juveniles that are placed in detention facilities are 4 times more likely to commit suicide than their non-incarcerated peers (CJJ, 2000). Each year, approximately 11,000 juveniles engage in 17,000 acts of suicidal behavior (CJJ, 2000). As of 2000, 75% of incarcerated juveniles resided in facilities that disregarded fundamental suicide prevention protocols (CJJ, 2000). A national survey by the Office of Juvenile Justice and Delinquency Prevention (2009) found that between 1995 and 1999, 110 youths successfully ended their lives; between 2002 and 2005, 42 juveniles in state facilities committed suicide (Bureau of Justice Statistics, 2007). The OJJDP's (2009) study found that the majority of suicide victims had a history of mental health issues (65.8%) and substance abuse (73.4%). The majority of victims were male (79.7%) Caucasians (68.4%) aged 15-17 (70%). Perhaps most tragically, most of these youths were incarcerated for offenses of a non-violent nature (69.6%) and could have been alternatively sentenced, and if possible, treated in their community.

As previously mentioned, screening and assessment is of vital importance for the youth that are in the custody of the juvenile justice system in order to increase their likelihood of receiving treatment. However, there is evidence that such interventions are particularly critical

in order to prevent suicide. Gallagher and Dobrin (2005) empirically examined the relationship between screening and suicidal behavior by reviewing census data from 3,690 juvenile justice facilities. It was found that overall, approximately 4% (or 159) needed to seek emergency medical care for detainees due to a suicide attempts on a monthly basis. Roughly 60% of facilities screened juveniles for suicidal behaviors and or risk factors and only 47% of facilities screened juveniles during their first 24 hours in the facility. The authors determined that there was a significant reduction of suicides among facilities that screened detainees in the first 24 hours compared to those that screened within 2 to 7 days. These findings demonstrate the need to quickly screen juveniles and do so effectively and in accordance with the recommended guidelines (Underwood and Grisso, 2003). This is particularly true in detention facilities, where only 34.5% of victims were assessed (OJJDP, 2009).

In a subsequent empirical examination of suicides among juvenile detainees from the census data utilized above, Gallagher and Dobrin (2006) identified several characteristics and processes that tended to occur at facilities that experienced suicides. In order to do so, the authors compared facilities where completed suicides occurred, where serious attempts occurred, and those without attempts or suicides. Facilities that possessed isolating or degrading characteristics, such as locked sleeping rooms, the use restraints, and the use of isolation were significantly more likely to have completed suicides (Gallagher & Dobrin, 2006). Analogous with estimates that minority and male populations are particularly undertreated for mental illness (Rawal, et al., 2004; Teplin et al., 2005), facilities that had more black and male detainees were also saw increased suicides. Finally, larger facilities, government-owned facilities, and reception/diagnostic centers were also at greater risk for completed suicides. It appears that the

way facilities operate and even their basic structure should be reexamined and, where possible, overhauled.

Facilities also need to answer the call of suicide victims by providing more training to staff, coming up with more coherent policies regarding suicide prevention, and otherwise modifying routine procedures. Based on the aforementioned findings, facilities can decrease the odds of a completed suicide by placing juveniles with a roommate and making sure that they are not isolated for long periods of time. However, the juvenile justice system faces a difficult problem, as some severely ill youths may be combative and warrant such isolation so that they do not harm other inmates and staff. One solution to this problem may be redesigning the rooms of high-risk juveniles, as nearly every juvenile (98.7%) identified by the OJJDP hanged themselves. It may be beneficial to ensure that fixtures (i.e. rafters, door knobs, etc.) cannot be utilized for this purpose. All in all, the way facilities are detecting and treating inmates at risk for suicide needs to evolve, as the system literally has thousands of lives in its hands.

Alternatives to the Status Quo

It is conceivable that there are more effective, humane alternatives to simply warehousing mentally ill youths and that identifying effective changes to policy can begin this process. Skowrya and Coccozza (2007) outlined a comprehensive model to improve the juvenile justice system's dealings with its mentally ill population. This proposed model encompasses several underlying principles. Juveniles should not be forced to turn to the justice system because of a lack of viable community options. Youth should be given treatment that is evidence-based (preferably in the community), adheres to special considerations (sex, age, orientation), and is developmentally appropriate (i.e. geared towards children rather than adults). The juvenile justice system should also improve efforts at coordinating treatment and services, both with other

agencies and the juvenile's family. Finally, the juvenile justice system's procedures for mental illness treatment and assessment should be empirically evaluated to ensure more positive outcomes.

Building upon these underlying principles, Skowrya and Coccozza (2007) also identified four "cornerstones" that should be followed by system. The first is collaboration; the juvenile justice system should attempt to collaborate with the mental health system throughout all areas and interventions. This has been done in Connecticut, where a multi-system team was created in order to implement policy improvements, and has demonstrated some success (Skowrya & Coccozza, 2007). The second cornerstone is identification. All juveniles who enter the system should undergo an assessment, particularly when they first enter the system or interact with law enforcement. Juveniles should also be regularly assessed for suicidal behavior and subjected to a more effective general screening. To this end, some facilities have begun using the MAYSI-2, a screening tool that has demonstrated promising scientific reliability and validity (see Cauffman, 2004; Skowrya & Coccozza, 2007). The third cornerstone identified was diversion. The authors contend that incarceration should be utilized only when youth pose a threat to society and are chronic offenders. If possible, juveniles should be treated in less restrictive community settings rather than on-site treatment facilities that require them to be incarcerated, abiding by the principle of placing youths in the least restrictive environment that is possible (Skowrya & Coccozza, 2007). The fourth and, arguably, most important cornerstone of Skowrya and Coccozza's (2007) model is treatment. Juveniles should be given empirically-validated, targeted treatment strategies that are provided by competent mental health professionals. Several states have begun to institute some of the above recommendations (see Skowrya & Coccozza, 2007 for a

review), but more progress is still needed given the substantial shortcomings that still exist in the system.

Conclusions and Discussion

It is deplorable that hundreds of youth in California and thousands across the country are incarcerated needlessly because community mental health services are not available. This is an urgent problem. We need to ensure that there are adequate resources in every community for children who need mental health care (Clarren, 2005, para. 7).

Currently, the juvenile justice system is experiencing a mental health crisis. This crisis was arguably born out of the failed policy of deinstitutionalization, which created a mental health system that is largely inaccessible to the average American, particularly those that do not have health coverage. The call of President Kennedy to replace the cold, unyielding mental institution with the warm embrace of the community has been largely unanswered. Instead, what has been left in the place of traditional mental institutions is a new-age, Frankenstein mental institution, one that is probably even more ineffectual, expensive, and demoralizing than its predecessor: the correctional facility. Yet, unlike the traditional mental institution, correctional facilities were not designed to take on the mentally ill in large quantities. In the case of juvenile justice facilities, serving as a source of psychiatric care has now become one of its responsibilities, as the proportion of mentally ill individuals has simply become too great to ignore any longer. The system cannot keep operating under the guise of “correction” and the welfare of juveniles when they are subjected to a lack of assessment, treatment, and proper reintegration back into the society that has failed to address their mental anguish. Based on the available evidence, it is clear that juveniles in the system are particularly likely to be mentally ill, sometimes seriously and in multiple ways. Such individuals, unfortunately, are not overwhelmingly likely to get the care that they need, as detention facilities, for a myriad of reasons, do not screen or assess juveniles as much as they should. Additionally, even if they are screened, for all too many

juveniles, it is not likely that they will be treated in a timely manner, if at all, and some will even take their own lives. If they are a minority, male, or both, they will be underserved, and if they are a girl, they are more likely to be ill in the first place.

These inconsistencies have created a particularly powerful conundrum for the juvenile justice system. Though the system was not designed with the intention of serving as a substitution for community health care, it has been saddled with a grave responsibility indicative of a deeper societal issue: a lack of care for the mentally ill. As a result, the public, as well as the criminal justice system needs to make a decision on what juvenile justice facilities are going to be: asylums, or correctional facilities, or some hybrid of both. However, it would seem that the true solution would be to actually fulfill the promise of the Community Health Center Act and provide community healthcare so that if juveniles become mentally ill, they do not have to be entered into the system to be managed. It is up to society to finish what the Community Health Center Act started nearly 50 years ago so that we can truly begin to prevent mental illness and treat it before juveniles spiral out of control.

At the same time, however, it is somewhat naïve to think that psychiatric functions can be completely eliminated from the juvenile justice system, and thereby, correctional facilities. Realistically, there will always be a need for psychological care for individuals in such institutions, as psychological dysfunction or substance abuse, for some, is intertwined with criminal offending. Further, youth that are incarcerated are more likely to have behavioral disorders than those placed in a community setting (Washburn, et al., 2008) which translates to incarcerated youth being more difficult to deal with, as these individuals may be simply too combative to treat in community settings. Thus, since juvenile justice system will inevitably deal with the mentally ill, it is imperative to make sure that it is done correctly and efficiently. This

can be achieved by following policy proposals rooted in empirical evidence, utilizing effective treatment and screening tools that have also been empirically supported, and ensuring that correctional staff is adequately trained regarding the sensitivities of mental illness. Only then can the system begin to end the process of simply warehousing mentally ill juveniles and make strides toward healing them.

References

- Abram, K. N., Choe, J. Y., Washburn, J. J., Teplin, L. A., King, D. C., & Dulcan, M. K. (2008). Suicidal ideation and behaviors among youths in juvenile detention. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(3), 291-300.
- Abram, K. M., Teplin, L. A., McClelland, G. M., & Dulcan, M. K. (2003) Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 60*, 1097 -1108.
- Bolante, R. (2006 August). Nowhere else to go: How the state is using its detention home as a warehouse for mentally ill kids. *Honolulu Magazine, August 2006 Issue*. Retrieved from <http://www.honolulumagazine.com/Honolulu-Magazine/August-2006>
- Bureau of Justice Statistics (2007). *Deaths in custody statistical tables*. Washington DC: U.S. Department of Justice.
- Burns, B. J. (1991). Mental health service use by adolescents in the 1970s and 1980s. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*, 144-150.
- Cauffman, E. (2004). A statewide screening of mental health symptoms among juvenile offenders in detention. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(4), 430-439.
- Chabra, A., Chavez, G. F., Harris, E.S. & Shah, R. (1999). Hospitalization for mental illness in adolescents: risk groups and impact on the health care system. *Journal of Adolescent Health, 24*, 349-356.
- Clarren, R. (2005 February). California jails serve as warehouses for mentally ill kids. *The New Standard*. Retrieved from <http://newstandardnews.net/content/index.cfm/items/1426>

- Coalition of Juvenile Justice (2000). *Handle with care: Serving the mental health needs of young offenders, 2000 annual report*. Retrieved from http://www.ncmhjj.com/resource_kit/pdfs/Overview/Readings/HandleWCare.pdf
- Cocozza, J. & Skowyra, K. (2000). Youth with mental health disorders: Issues and emerging responses. *Office of Juvenile Justice and Delinquency Prevention Journal*, 7, 3-13.
- Desai, R. A., Goulet, J. L., Robbins, J., Chapman, J. F., Migdole, S. J., & Hoge, M. A. (2006). Mental health care in juvenile detention facilities: A review. *Journal of the American Academy of Psychiatry and the Law*, 34, 204-214.
- Elrod, P., & Ryder, R. S. (2011). *Juvenile justice: A social, historical, and legal perspective, third edition*. Sudbury, MA: Jones and Bartlett Publishers, LLC.
- Etter, G.W., Birzer, M.L., & Fields, J. (2008). The jail as a dumping ground: The incidental incarceration of mentally ill individuals. *Criminal Justice Studies: A Critical Journal of Crime, Law and Society*, 21(1), 77-87.
- Fazel, S., Doll, H., & Långström, N. (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: A systematic review and metaregression analysis of 25 surveys. *Child and Adolescent Psychiatry*, 47, 1010-1019.
- Feinstein, A., Lampkin, A., Lorish, C. D., Klerman, L. V., Maisiak, R., & Kim Oh, M. (1998). Medical status of adolescents at time of admission to a juvenile detention center. *Journal of Adolescent Health*, 22(3), p.190-196. Doi:10.1016/S1054-139X(97)00169-9
- Gallagher, C. A. & Dobrin, A. (2006). Facility-level characteristics associated with serious suicide attempts and deaths. *Suicide and Life-Threatening Behavior*, 36, 363-375.

- Gallagher, C. A. & Dobrin, A. (2005). The association between suicide screening practices and attempts requiring emergency care in juvenile justice facilities. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 485-493.
- Gottschalk, M. (2009). Money and mass incarceration: The bad, the mad, and penal reform. *Criminology and Public Policy*, 8(1), 1201-1213.
- Goldstrom, I., Jaiquan, F., & Henderson, M. (2000). *The availability of mental health services to young people in juvenile justice facilities: A survey, in mental health, United States, 2000*. Washington DC: Center for Mental Health Services.
- Grisso, T. & Underwood, L. (2003). *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System*. Delmar, NY: National Center for Mental Health and Juvenile Justice. Retrieved from <http://www.eric.ed.gov/PDFS/ED478677.pdf>
- Grob, G. (1994). *The mad among us: A history of the care of America's mentally ill*. New York, NY: The Free Press.
- Human Rights Watch (2003). *Ill-equipped: U.S. prisons and offenders with mental illness*. Retrieved from www.hrw.org/en/reports/2003/10/21/ill-equipped
- Innes, C. A. (1997). Patterns of misconduct in the federal prison system. *Criminal Justice Review*, 22, 157-174.
- Isaac, R. J. & Armat, V. C. (1990). *Madness in the streets: How psychiatry and the law abandoned the mentally ill*. New York, NY: The Free Press.
- Karnik, N. S., Soller, M., Redlich, A., Silverman, M., Kraemer, H. C., Haapanen, R., & Steiner, H. (2009). Prevalence of and gender differences in psychiatric disorders among juvenile delinquents incarcerated for nine months. *Psychiatric Services*, 60(6), 838-841.

- McReynolds, L. S., Schwalbe, C. S., & Wasserman, G. A. (2010). The contribution of psychiatric disorder to juvenile recidivism. *Criminal Justice and Behavior*, 37, 204-216.
- Magaletta, P. R., Diamond, P. M., Faust, E., Daggett, D. M., & Camp, S. D. (2009). Estimating the mental illness component of service need in corrections: Results from the mental health prevalence project. *Criminal Justice and Behavior*, 36, 229-242.
- MacReady, N. (2009 August 22). US faces crisis in mental health care for juvenile offenders. *The Lancet*, 374(9690). Retrieved from <http://www.thelancet.com>
- Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 49, 980-989.
- Muschert, G. W. (2007). The Columbine victims and the myth of the juvenile superpredator. *Youth Violence and Juvenile Justice*, 5, 351-366.
- Moore, S. (2009). Mentally Ill Offenders Strain Juvenile System. *New York Times*. August 20. Retrieved from http://www.nytimes.com/2009/08/10/us/10juvenile.html?_r=1&sq=mentally_ill_juveniles&st=cse&adxnnl=1&scp=1&adxnnlx=1291564866-b91qlBMw/iazjADQpHntkA
- National Alliance on Mental Illness (2010). *What is mental illness: Mental illness facts*. Retrieved from http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness>About_Mental_Illness.htm

- National Commission on Correctional Health Care (2004). *Standards for health services in juvenile detention and confinement facilities*. Chicago: National Commission on Correctional Health Care.
- Office of Juvenile Justice and Delinquency Prevention (2009). *Juvenile Suicide in Confinement: A national survey*. Washington DC: U.S. Department of Justice.
- Office of Juvenile Justice and Delinquency Prevention (1994). *Conditions of Confinement: juvenile detention and corrections facilities*. Washington DC: U.S. Department of Justice.
- Otto, R.K., Greenstein, J.J., Johnson, M.K., & Friedman, R.M. (1992). Prevalence of mental disorders among youth in the juvenile justice system. *In Responding to the Mental Health Needs of Youth in the Juvenile Justice System*, J.J. Coccozza (Ed.). Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, pp. 7-48.
- Rawal, P., Romansky, J., Jenuwine, M., & Lyons, J. S. (2004). Racial differences in the mental health needs and service utilization of youth in the juvenile justice system. *The Journal of Behavioral Health Services and Research*, 31(3), 242-254.
- Roberts, A. (2004). Treating juveniles in institutional and open settings. In A. R. Roberts (Ed.), *Juvenile Justice Sourcebook: Past, present, and future*. New York, NY: Oxford press.
- Sabol, W. J., West, H. C., & Cooper, M. (2010). *Prisoners in 2008 (no. NCJ 228417)*. Washington DC: Bureau of Justice Statistics. Retrieved from <http://bjs.ojp.usdoj.gov/content/pub/pdf/p08.pdf>
- Sheidow, A. J., Bradford, W. D., Henggeler, S. W., Rowlan, M. D., Halliday-Boykings, C., Schoenwald, S. K., & Ward, D. M. (2004). Treatment costs for youths receiving

- multisystemic therapy or hospitalization after a psychiatric crisis. *Psychiatric Services*, 55, 548-554.
- Siegel, L. J. & Welsh, B. C. (2009). *Juvenile Delinquency: Theory, practice, and law, tenth edition*. Belmont, CA: Wadsworth.
- Shufelt, J. L. & Cocozza, J. J. (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study*. Delmar, NY: National Center for Mental Health and Juvenile Justice. Retrieved from <http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf>
- Sickmund M., Sladky T. J., & Kang W. (2005). Census of Juveniles in Residential Placement Databook. Retrieved from <http://www.ojjdp.ncjrs.org/ojstatbb/cjrp>.
- Skowrya, K. R. & Cocozza, J. J. (2007). *Blueprint for change: A comprehensive model for the identification of treatment of youth with mental health needs in contact with the criminal justice system*. Delmar, NY: The National Center for Mental Health and Juvenile Justice Research Report.
- Teplin L. A., Abram K. M., & McClelland G. M., (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59, 1133–1143.
- Teplin, L. A., Abram, K. M., McClelland, G. M., Washburn, J. J., & Pikus, A. K. (2005). Detecting mental disorder in juvenile detainees: Who receives services. *American Journal of Public Health*, 95(10) 1773-1780.
- Trupin, E. W., Turner, A. P., Stewart, D., & Wood, P. (2004). Transition planning and recidivism among mentally ill juvenile offenders. *Behavioral Sciences & the Law*, 22, 599-610.

- Twedt, S. (2001, December 9). Juvenile lockups ill-equipped to care for young people considering suicide. *Pittsburgh Post-gazette*. Retrieved from <http://www.post-gazette.com/>
- United States House of Representatives (2004). *Incarceration of youth who are waiting for community mental health services in the United States*. Report by the Committee on Government Reform, Minority Staff Special Investigations Division: Washington, DC. Retrieved from http://healingattention.org/documents/doc_mhjustice.pdf
- Vidal, S. & Skeem, J. (2007). Effect of psychopathy, abuse, and ethnicity on juvenile probation officers' decision-making and supervision strategies. *Law & Human Behavior*, 5, 479-498.
- Von Zielbauer, P. & Plambeck, J. (2005, February 28). Missed signals in New York jails open way to season of suicides. *The New York Times*. Retrieved from http://www.nytimes.com/2005/02/28/nyregion/28jail.html?_r=1&scp=1&sq=Missed%20signals%20in%20New%20York%20jails%20open%09way%20to%20season%20of%20suicides&st=cse
- Washburn, J. J., Teplin, L. A., Voss, L. S., Simon, C. D., Abram, K. M., & McClelland, G. M. (2008). Psychiatric disorders among detained youths: A comparison of youths processed in juvenile court and adult criminal court. *Psychiatric Services*, 59, 965-973.
- Weithorn, L. A. (1988). Mental hospitalization of troublesome youth: An analysis of skyrocketing admissions rates. *Stanford Law Review*, 40(3), 773-838.
- Wooley, J. T. & Peters, G. (2010). Special Message to the Congress on Mental Illness and Mental Retardation. *The American Presidency Project*. Retrieved from <http://www.presidency.ucsb.edu/ws/?pid=9546>