JUVENILE OFFENDING

Introduction

Mental health disorders are common among youth involved in the juvenile justice system. The National Center for Mental Health and Juvenile Justice (NCMHJJ) and the Council of Juvenile Correctional Administrators conducted a study of the prevalence of mental health disorders in youth involved in the juvenile justice system. According to this study, 70 percent of these youth met the criteria for at least one mental health disorder, and approximately a quarter of all youth in the juvenile justice system experienced a mental health disorder so severe that they required critical and immediate treatment (McGarvey, 2012; NCMHJJ, 2006). Further studies reveal that approximately 50 to 75 percent of the 2 million youth encountering the juvenile justice system met criteria for a mental health disorder (Underwood & Washington, 2016). Moreover, in previous studies of juvenile offender detention facilities, two-thirds of males and three-quarters of females in these facilities were found to meet criteria for at least one mental health disorder, and an additional one-tenth also met criteria for a substance use disorder (Underwood & Washington). Such numbers are particularly troubling when compared to the general youth population, among which only about 20 percent of youth suffer from a diagnosable mental health disorder.

In Virginia, more than 92 percent of juveniles committed to the Department of Juvenile Justice have significant symptoms of attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), oppositional defiant disorder (ODD), or a substance use disorder (Virginia Department of Juvenile Justice [VDJJ], 2016). More than 64 percent of admitted juveniles had significant symptoms of other mental health disorders, with a higher percentage of females (89.5 percent) than males (62.7 percent) having significant symptoms of a mental health disorder (excluding those disorders previously listed). Moreover, a higher percentage of females (73.7 percent) than males (60.3 percent) had also been prescribed psychotropic medication (VDJJ).

Youth with mental health disorders may have symptoms involving impulsiveness, anger, and cognitive misperception that can make them a greater risk to themselves or others, especially if they are under the stress associated with an offense and arrest (Grisso, 2008). Among youth who are detained, a significant number are likely to have mental disorders that create unmanageable behaviors. Thus, it is no surprise that youth with mental disorders contribute disproportionately to detention populations.

Of youth involved with the juvenile justice system, approximately 15 to 30 percent have been diagnosed with depression or dysthymia, 13 to 30 percent have been diagnosed with ADHD, three to seven percent have been diagnosed with bipolar disorder, and 11 to 32 percent have been diagnosed with posttraumatic stress disorder (PTSD) (Underwood & Washington, 2016). Grisso (2008) also noted that both CD and substance use disorders are quite prevalent in youth. The psychiatric disorders seen most commonly in juvenile offenders are listed in Figure 1.

Figure 1
Most Common Mental Health Disorders and Issues Seen Among Juvenile Offenders

- Conduct disorder (CD)
- Oppositional defiant disorder (ODD)
- Major depressive disorder
- Dysthymic disorder
- Manic episodes
- Attention-deficit/hyperactivity disorder (ADHD)
- Posttraumatic stress disorder (PTSD)
- Substance use disorders

Sources: Underwood & Washington, 2016; Grisso, 2008.

In 2013, the American Psychiatric Association (APA) released the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) to replace the fourth text revision (*DSM-IV-TR*). The *DSM-5* is a manual for assessment and diagnosis of mental health disorders and does not include information for treatment of any disorder (APA, 2013). In the future, more evidence supporting treatments of disorders with *DSM-5* classifications will be available as clinical studies utilizing *DSM-5* criteria are conducted. As a result, this *Collection* will reference studies that utilize *DSM-IV-TR* diagnostic criteria to explain symptoms and treatments.

Risk and Protective Factors

Several risk factors predict violent juvenile offending. However, one must take care not to assume that a risk or protective factor will predict particular outcome. No single risk factor leads a young person to delinquency. Risk factors "do not operate in isolation and typically are cumulative: the more risk factors that [youth] are exposed to, the greater likelihood that they will experience negative outcomes, including delinquency" (Kendziora and Osher, 2004). The factors that place youth more at risk for perpetuating violence are identified by the Centers for Disease Control (CDC) and include:

- Impulsiveness
- Youth substance use
- Antisocial or aggressive beliefs and attitudes
- Low levels of school achievement
- Weak connection to school
- Experiencing child abuse and neglect

- Exposure to violence in the home or community
- Involvement with delinquent peers or gangs
- Lack of appropriate supervision
- Parental substance abuse
- Parental or caregiver use of harsh or inconsistent discipline (Farrington, Ttofia, & Piquero, 2016; David-Ferdon et al., 2016)

The presence of more than one mental health disorder also serves as a risk factor for juvenile offending, placement within the juvenile justice system, and increased likelihood of recidivism (Cottle, Lee, & Heilbrun, 2001). Furthermore, certain mental health disorders, such as affective disorders (depression, bipolar disorder, and anxiety disorders) and substance use disorders, increase risk (Schubert, Mulvey, & Alderfer, 2011). The findings of a study conducted by the Research and Training Center on Family Support and Children's Mental Health (2001) indicated that children at risk for institutional placement were placed according to the primary type of dysfunction they displayed, with behaviorally disordered children being incarcerated and emotionally disordered children being placed into the state mental health system. A more recent study found that among youth in the juvenile court delinquent population, those diagnosed with bipolar disorder were eight times more likely to be placed in detention for committing a personal crime (a violent crime against an individual) than those who did not have this disorder (Stoddard-Dare, Mallett, & Boitel, 2011). Surprisingly, this study also found that youth with either ADHD or a CD were somewhat less likely to commit a personal crime and be subsequently placed in detention. The study's authors hypothesize that, because the diagnostic criteria used to determine diagnosis and severity was based observable behaviors (e.g., hyperactive behaviors, fidgety, and/or nervous for ADHD and aggression and/or violations of norms for CD), and because ADHD and CD symptoms are often readily observable and frequently impact or distract others, interventions to assist these youth may have been pursued earlier and on a more consistent basis (Stoddard-Dare, Mallet, & Boitel).

The NCMHJJ (2005) identified gender-specific risk that may also influence high-risk behaviors linked to delinquency. There is evidence that females in the juvenile justice system are more likely to have experienced certain types of trauma (e.g., sexual abuse and rape) than males (Zahn et al., 2010). Accordingly, these differences have also been noted as mental health risk factors for delinquency. For example, females in the juvenile justice system who have mental health disroders such as depression, anxiety, and PTSD may also have life stressors and experiences of victimization that are linked to these disorders (Zahn et al.).

Carr and Vandiver (2001) have identified a variety of protective factors that are associated with lower rates of recidivism among youth offenders. These protective factors are personal, familial, social, and academic (Carr & Vandiver). For example, juveniles with a lower risk for recidivism reported being happier with themselves, had more positive attitudes toward school rules and law enforcement, and had more structure and rules within their homes. Other protective factors outlined by David-Ferdon (2016) include healthy problem-solving and emotional regulation skills as well as higher rates of school readiness and academic achievement. Positive parent-youth relationships, in which parents set consistent, developmentally appropriate limits and demonstrate interest in their children's education and social relationships, were also associated with healthy youth development and the prevention of violent behavior (David-Ferdon et al.). Additional factors that contribute to healthy adolescent development and decreased aggressive behaviors include youth feeling connected to their schools, experiencing academic success, and having positive relationships with teachers, other caring adults, and prosocial and nonviolent peers (David-Ferdon et al.).

Screening and Assessment

The following is taken from the NCMHJJ (2016). Although mental health disorders are common among youth involved in the juvenile justice system, these mental health problems frequently go undetected, increasing the likelihood that these juveniles will have persistent difficulties. Screening and assessment of juvenile offenders helps determine how the juvenile justice system can address their treatment needs. Screening also identifies youth who may require further attention or may have serious needs. Being "screened in" on a screening tool does not necessarily mean that a youth has a diagnosable mental health or substance use disorder or a significant risk of harming him/herself or someone else. However, it does indicate that further follow-up is necessary to determine the presence of a suspected condition.

Assessment tools may help officials and mental health professionals determine if a child who has come in contact with the juvenile justice system displays signs of mental disturbance or emotional distress (Heilbrun, Cottle, & Lee, 2001). Assessments are conducted to provide a more detailed description of:

- The youth's history;
- Clinical needs;
- Functioning across several domains (e.g., family, peers, school);
- Risk and protective factors; and
- Recommendations for management or treatment.

As noted by Hammond (2007), another important purpose of assessment is to address the legal issues surrounding a juvenile's competency to understand the adjudicatory process and to thoughtfully participate in and make decisions during that process. Incompetence to stand trial is typically related to a mental disorder or developmental disability. Table 1 lists the assessment tools described in this section.

Table 1
Evidence-based Assessment Tools Used with Juvenile Offenders

Name of Measure	Description
Youth Level of Services/Case Management Inventory (YLS/CMI)	Estimates a youth's risk of recidivating and need for services.
Youth Assessment and Screening Instrument (YASI)	Includes a prescreen section that identifies moderate- or high-risk youths, who are then administered the full assessment.
Structured Assessment of Violence Risk in Youth (SAVRY)	Estimates the risk of youth committing a specific offending behavior.
Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2)	Measures symptoms on seven scales pertaining to areas of emotional, behavioral, or psychological disturbance, including suicide ideation.
Suicidal Ideation Questionnaire (SIQ)	This 25-item self-report screening instrument is used to assess suicidal ideation in adolescents.
Global Appraisal of Individual Needs – Short Screener (GAIN-SS)	This 20-item behavioral health screening tool is designed to identify adolescents in need of more detailed assessment for substance use or mental disorders.
Voice-Diagnostic Interview Schedule for Children (Voice-DISC)	This self-report, computerized tool assesses youth for various mental health disorders.

Sources: OJJDP, 2015; Vincent, 2011.

The following three examples of risk/needs assessments that illustrate the variety of formats that assessment tools can take, as outlined by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) (2015). The Youth Level of Services/Case Management Inventory (YLS/CMI) is an example of an assessment instrument that estimates a youth's risk of recidivating and need for services based on a variety of factors. The Youth Assessment and Screening Instrument (YASI) is an example of an instrument that includes a prescreen section that identifies moderate- or high-risk youth, who are then administered the full assessment. The Structured Assessment of Violence Risk in Youth (SAVRY) is an example of an assessment designed to estimate the risk of youth committing a specific offending behavior (i.e., violent acts).

The information in the following paragraphs is taken from Vincent (2011). There are several mental health screening tools that can be used by juvenile justice personnel. The Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) measures symptoms on seven scales pertaining to areas of emotional, behavioral, or psychological disturbance, including suicide ideation. The Suicidal Ideation Questionnaire (SIQ) is a 25-item self-report screening instrument used to assess suicidal ideation in adolescents. It can be administered individually or in a group setting. The Global Appraisal of Individual Needs – Short Screener (GAIN-SS) is a 20-item behavioral health screening tool designed to identify adolescents in need of more detailed assessment for substance use or mental disorders. Many studies have been conducted to demonstrate that this tool accurately identifies drug and alcohol problems. The Voice-Diagnostic Interview Schedule for Children (Voice-DISC) is a self-report, computerized tool. There are also several more comprehensive mental health assessment tools that are used in many youth systems and have research evidence that supports their validity.

Comorbid Disorders

Information in this section is taken from Teplin et al. (2006). Research conducted of youth in detention indicates substantial comorbidity of mental health disorders in both females and males. The Northwestern Juvenile Project, a large-scale study of the mental health needs of delinquent youth, revealed that more than half of incarcerated females (56.5 percent) and almost half of males (45.9 percent) had more than one mental health disorder. The study also noted that only one-fifth of youth in detention had just one mental health disorder. Nearly one-third of females (29.5 percent) and males (30.8 percent) had substance use disorders and ADHD or disruptive behavior disorders, and approximately half of these youth also had anxiety disorders, affective disorders (e.g., depression, bipolar disorder, or anxiety disorder), or both. Disorder patterns also varied by gender. For instance, significantly more females (47.8 percent) than males (41.6 percent) had two or more of the following types of disorders: affective disorders, anxiety disorders, substance use, and ADHD or disruptive behavior. Moreover, more females (22.5 percent) than males (17.2 percent) had three or more types of disorders.

The comorbidity of substance use disorders is also of particular concern. Among the disorders assessed, juveniles who were detained were more likely to have substance use plus ADHD or disruptive behavior disorders than any other combination. Half of these detainees also had an affective or anxiety disorder. Females had higher rates than males of many single and comorbid psychiatric disorders, including major depressive episodes, some anxiety disorders, and substance use disorders other than alcohol and marijuana (e.g., cocaine and hallucinogens). Solutions for treating co-occurring substance use disorders for youth in the justice system are complicated, particularly because adolescents often return to the peer, family, and community environments that initially supported and promoted their substance use.

Treatments

Heightened awareness of mental health disorders has led to increased research and new treatment practices in the juvenile justice system. Among delinquent juveniles who receive structured, meaningful,

and sensitive treatment, recidivism rates are 25 percent lower than those in untreated control groups. Highly successful programs reduce rates of recidivism by as much as 80 percent (Coalition for Juvenile Justice, 2000). Youth within the juvenile justice system have different mental health needs that require differing levels of care. This necessitates an effective screening and assessment processes, as well as varied treatment options (Underwood & Washington, 2016). It is also important to note that youth involved in the juvenile justice system also have specific criminogenic risks and needs. Interventions that reduce the risk of re-offending may be broader than mental health treatments outlined in the paragraphs that follow and may be more appropriate for juveniles with acute needs and risk factors.

Effective interventions incorporate several treatment components that are discussed in the following paragraphs. Table 2 outlines these treatments.

Table 2
Summary of Treatments for Juvenile Offenders

What Works	
Multisystemic therapy (MST)	An integrative, family-based treatment with a focus on improving psychosocial functioning for youth and families.
Functional family therapy (FFT)	A family-based program that focuses on delinquency, treating maladaptive and "acting out" behaviors, and identifying obtainable changes.
Treatment Foster Care Oregon (TFCO)	As an alternative to corrections or residential treatment, TFCO places juvenile offenders with carefully trained foster families who provide youth with close supervision, fair and consistent limits, consequences, and a supportive relationship with an adult. The program includes family therapy for biological parents, skills training and supportive therapy for youth, and school-based behavioral interventions and academic support.
What Seems to Work	
Family centered treatment (FCT)	FCT seeks to address the causes of parental system breakdown while integrating behavioral change. FCT provides intensive in-home services and is structured into four phases: joining and assessment, restructuring, value change, and generalization.
Brief strategic family therapy	A short-term, family-focused therapy that focuses on changing family interactions and contextual factors that lead to behavior problems.
Aggression replacement therapy (ART)	A short-term, educational program that focuses on anger management and provides youth with the skills to demonstrate non-aggressive behaviors, decrease antisocial behaviors, and utilize prosocial behaviors.
Cognitive behavioral therapy (CBT)	A structured, therapeutic approach that involves teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that will lead to more adaptive behavior in challenging situations.
Dialectical behavior therapy	A therapeutic approach that includes individual and group therapy components and specifically aims to increase self-esteem and decrease self-injurious behaviors and behaviors that interfere with therapy.

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Home and Community-Based Models

Although several of the following treatment approaches may be applied and utilized in the institutional setting, this discussion refers to the application of these approaches in a community setting.

Multisystemic Therapy

Multisystemic therapy (MST) is an integrative, family-based treatment that focuses on improving psychosocial functioning in youth and families with the goal of reducing or eliminating the need for out-of-home placements (Henggeler et al., 2009). MST addresses the numerous factors that shape serious antisocial behaviors in juvenile offenders while focusing on the youth and his or her family, peers, school, and neighborhood/community support (Henggeler, as cited by the NCMHJJ, 2002; Coalition for Evidence-Based Policy, n.d.). The underlying premise of MST is that the behavioral problems in children and adolescents can be improved through the interaction with or between two or more of these systems.

MST has an extensive body of research to support its effectiveness in juveniles who have emotional and behavioral problems. It is considered to be an effective, intensive, community-based treatment for justice-involved youth (Zajac, Sheidow, & Davis, 2015). Evaluations have shown reductions of up to 70 percent in long-term rates of re-arrest, reductions of up to 64 percent in out-of-home placements, improvements in family functioning, and decreased mental health problems (National Mental Health Association, NMHA [now Mental Health America, MHA], 2004).

Functional Family Therapy

Functional family therapy (FFT) is a family-based prevention and intervention program that integrates established clinical therapy, empirically supported principles, and extensive clinical experience. FFT is often used for youth ages 11 to 18 who are at risk for and/or presenting with delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, or disruptive behavior disorders (Underwood & Washington, 2016). This model allows for intervention in complex problems through clinical practice that is flexibly structured, culturally sensitive, and accountable to families (Sexton & Alexander, as cited by the NCMHJJ, 2002).

FFT focuses on treating youth who exhibit delinquency and maladaptive "acting out" behaviors by seeking to reduce them by identifying obtainable changes (NMHA, 2004). A research study indicated that one year after treatment youth who participated in FFT had a re-arrest rate of approximately 25 percent (NMHA). This was significantly lower than the arrest rate (45 to 75 percent) for youth who had not received FFT (NMHA). Numerous FFT outcome studies have been published, with participants ranging in clinical severity from status offenders to youth presenting serious antisocial behavior. Most of these studies demonstrated favorable decreases in antisocial behavior for youth who participated in FFT (Henggeler & Schoenwald, 2011).

Treatment Foster Care Oregon

Treatment Foster Care Oregon (TFCO) (formerly Multidimensional Treatment Foster Care) recruits, trains, and supervises foster families to provide youth with close supervision, fair and consistent limits and consequences, and a supportive relationship with an adult (NCMHJJ, 2002). As an alternative to corrections, it places juvenile offenders who require residential treatment with these carefully trained foster families (American Academy of Child and Adolescent Psychiatry [AACAP], 2013). TFCO also provides individual and family therapy, educational programming, and psychiatric care. It is effective in reducing delinquent behaviors, justice system contacts, substance use, depression, and teen pregnancy and promotes both rehabilitation and public safety (Zajac, Sheidow, & Davis, 2015; Chamberlain, 1998). During the placement timeframe, the youth's biological or adoptive family also receives family therapy to further the goal of returning the youth to that family (NMHA, 2004).

Chamberlain (1998) found that TFCO was superior to traditional group care in short- and long-term outcomes among juvenile offenders. These outcomes included decreases in running away from home, higher rates of program completion, and decreases in the frequency of being locked up in a detention or training center. Research has shown that male juvenile offenders who participated in TFCO, as compared to traditional group care, were more likely to return home to reside with relatives and to have less official and self-reported criminality (e.g., violent crimes or delinquent behaviors) (Chamberlain & Reid, 1998).

Family Centered Treatment

The information in the following paragraph is from the Institute for Family Centered Treatment (Sullivan, Bennear & Painter, 2009). A treatment approach that shows promise is family centered treatment (FCT). FCT was developed by the Institute for Family Centered Services (IFCS) as an intensive, in-home treatment. The goal of FCT is to keep youth in the community and divert them from further penetration into the juvenile justice system. FCT seeks to address the causes of parental system breakdown while integrating behavioral change. FCT is structured into four phases: joining and assessment, restructuring, value change, and generalization.

The FCT program performs at least as well as residential programs and at a substantially lower cost. One study found that, in the first year following treatment, 11 percent fewer youth were in secure detentions, 23 percent fewer youth were in residential placements, 16 percent fewer youth were pending placements, and there was a 30 percent reduction in length of residential placement. Additional research is needed to show the long-term effectiveness of FCT.

Psychological Treatments

Psychological treatments provide guidance and support for juveniles with mental disorders (NCMHJJ, 2007). Treatments are conducted by appropriately trained and licensed mental health professionals. The type and length of treatment varies according to individual treatment plans (NCMJJ). Some examples of psychological treatments are discussed below.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a therapeutic approach that focuses on the relationship between thoughts, feelings, and behaviors in maladaptive outcomes. For example, CBT may focus on the idea that dysfunctional thoughts lead to maladaptive behaviors and feelings. This structured approach involves teaching youth about the relationship between their thoughts and their behaviors, and helps them employ more adaptive behaviors in challenging situations. This approach is especially beneficial for youth in the juvenile justice system because it is very structured and focuses on the triggers for disruptive or aggressive behavior (NMHA, as cited by the NCMHJJ, 2002). CBT addresses poor interpersonal and problem-solving skills by teaching participants social skills, coping, anger management, self-control, and/or social responsibility (NMHA, 2004). A meta-analysis highlighted the effectiveness of CBT in treating convicted offenders, specifically highlighting the impact of CBT in reducing future delinquency and recidivism rates and displaying the positive effects of cognitive restructuring and skills (Underwood & Washington, 2016; Wilson, Bouffard, & MacKenzie, 2005). However, follow-up studies found that that without changing the contextual factors that instill and reinforce maladaptive social decision-making and provide opportunities for continued behavior problems (e.g., time with delinquent peers, school expulsion), disruptive behaviors may persist (McCart & Sheidow, 2016).

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) was originally developed and validated for use with individuals with borderline personality disorder, but has since been adapted to treat juvenile offenders (Linehan et al., 1991). It consists of individual and group therapy components and focuses on validating the behaviors

and feelings of the juvenile. It also focuses on the youth making positive changes, such as developing emotional regulation skills *(*Skowyra & Cocozza, 2006). DBT specifically aims to increase self-esteem and decrease self-injurious and other negative behaviors that interfere with therapy. Linehan and colleagues highlighted positive outcomes associated with DBT, including decreases in substance abuse, crisis situations, and suicidal ideation, and increases in treatment retention. One study adapted DBT for the treatment of incarcerated female juvenile offenders and found a significant decrease in problem behaviors in these females (Trupin et al., 2002).

Brief Strategic Family Therapy

Brief strategic family therapy is a short-term, family-focused therapy that concentrates on changing family interactions and contextual factors that may lead to behavior problems in youth (U.S. Department of Health and Human Services, 2004). It includes three therapeutic techniques: developing a therapeutic alliance with family members, diagnosing the problem behavior(s), and restructuring or changing family interactions that lead to these problem behaviors. Brief strategic family therapy has been linked to decreases in substance abuse, reductions in negative attitudes and behaviors, and improvements in positive attitudes and behaviors (U.S. Department of Health and Human Services).

Aggression Replacement Therapy

Aggression replacement therapy (ART) is a short-term, educational program that focuses on anger management and provides youth with the skills to decrease antisocial behaviors and to utilize prosocial behaviors. The three main components of ART are structured learning training (learning interpersonal and social skills), anger control training (learning how to deal with one's anger), and moral reasoning (learning how to develop mature moral reasoning) (Skowyra & Cocozza, 2006). Research has shown ART to be associated with productive interpersonal interactions, improved problem-solving skills, and increased moral reasoning (Glick & Goldstein, 1987).

Additional Treatment Considerations

Pharmacological treatments may be incorporated as a part of the juvenile's treatment plan when being utilized for a diagnosed mental health disorder. Evidence-based pharmacological treatments for various mental health disorders are discussed in greater detail in each of the *Collection*'s sections on specific disorders.

In addition to these specific treatment programs, researchers and policymakers have described some broader approaches or philosophies that are thought to produce positive outcomes for juvenile offenders. One such approach is the integrative systems of care (SOC) approach. The SOC approach typically involves collaboration across agencies, such as juvenile justice and mental health, with the goal of developing coordinated plans for family-centered services that build upon the strengths of youth and their families.

The Coalition for Juvenile Justice (2000) outlined nine components that are critical to effective treatment for juvenile offenders:

1. Highly structured, intensive programs focusing on changing specific behaviors;
2. Development of basic social skills;
3. Individual counseling that directly addresses behavior, attitudes, and perceptions;
4. Sensitivity to a youth's race, culture, gender, and sexual orientation;
5. Family member involvement in the treatment and rehabilitation of children;
6. Community-based, rather than institution-based treatment;
7. Services, support, and supervision that "wrap around" a child and family in an individualized way;

8. Recognition that youth think and feel differently than adults, especially under stress; and
9. Strong aftercare treatment.

Unproven Treatments

Sukhodolsky and Ruchkin (2006) reviewed the treatments generally used for youth in the juvenile justice system and highlighted the limited application of evidence-based treatments to juvenile offenders. In short, although there may be ample evidence for treating youth with various psychopathologies, there is limited research on the implementation of these treatments in the juvenile justice system. This limitation highlights the need for more research to examine the effectiveness of these treatments among the juvenile offender population.

Research conducted with adult offenders who have mental health disorders revealed that interventions are effective during periods of confinement and that services should not be delayed (Morgan et al., 2012). Significant treatment gains can begin during confinement that can reduce the likelihood of recidivism and relapse. Ensuring continuity of care has been shown to reduce the rate of psychiatric hospitalizations and improve transition to the community. This is particularly important because the majority of juvenile offenders placed in confinement will eventually be released back to their communities.

Cultural Considerations

The U.S. Surgeon General's Report on Culture, Race, and Ethnicity indicates a lack of research on culturally sensitive, evidence-based mental health assessments and treatments for minority youth in the juvenile justice system (2001). This report highlights the need for considering race and ethnicity in treatment outcomes, particularly because minority youth are overrepresented in the juvenile justice system (Snyder & Sickmund, 1999).

One study found that incarcerated African-American youth had the lowest rate of mental health diagnoses, non-Hispanic Caucasian youth had the highest rate, and the rate for Hispanic youth fell between these two groups (Teplin et al., 2002). Thus, white youth in the juvenile justice system may, on average, be more dysfunctional (have greater psychiatric morbidity) than minorities. However, as discussed in the research, interpreting and evaluating rates of mental health diagnoses within the juvenile justice system can be difficult among minority youth, particularly if these youth are reluctant to admit mental health concerns or if their families have a cultural bias against seeking care (American Academy of Pediatrics Committee on Adolescence, 2011).

In a study of abuse and psychological problems of children in juvenile detention centers, as many as two-thirds of males and three-quarters of females suffered at least some physical abuse prior to incarceration. The physical abuse was more likely to be severe in non-Hispanic Caucasian and Hispanic females than in African-American females, and non-Hispanic Caucasian males were more likely than Hispanic or African-American males to suffer several types of physical abuse (King, et al., 2011). Non-Hispanic Caucasian females were more likely to be sexually abused than Hispanic or African-American females (King, et al.).

Non-Hispanic Caucasian youth in juvenile detention are more likely to have comorbid mental health disorders. This is true in females and in males (Abram et al., 2003). Non-Hispanic Caucasian and Hispanic youth were also more likely than African American youth to have drug and alcohol abuse disorders (Abram et al.). Although minorities have lower rates of comorbidity, they comprise up to two-thirds of youth in the juvenile justice system and are more likely to require services to address their comorbid disorders than non-minority youth (Abram et al.).

Services in Virginia

Each year, a significant number of juveniles with mental health problems enter Virginia's juvenile justice system. The Virginia Department of Juvenile Justice (VDJJ) assesses juveniles as they enter the system to ascertain their needs and what services are to be provided. Below is information about several Virginia-specific initiatives.

Services in Juvenile Detention Facilities

The following information is from the Virginia Department of Behavioral Health and Developmental Services (K. Hunter, personal communication, October 16, 2017). Virginia's local community service boards (CSBs) provide mental health screening, assessment services, and community-based referrals for youth in local juvenile detention facilities. A CSB's primary role in a juvenile detention center is providing short-term mental health and substance abuse services to juveniles incarcerated in the center with mental illnesses or mental illnesses and co-occurring substance use disorders. As part of this role, CSBs consult with juvenile detention center staff on the needs and treatment of juveniles. This may include case consultation with detention center staff. Since the juveniles have been court ordered to the center, they are under the jurisdiction of the center for care. CSBs provide consultation and behavioral health services in support of the centers care of juveniles. Target populations are those juveniles admitted to the designated detention center who are:

- Admitted to detention for a delinquent act;
- Determined to be in need of mental health services according to the MAYSI-II or by referral; and
- Not in need of immediate hospitalization.

Clinical services in juvenile detention are designed to provide short-term mental health and substance use services. A CSB may provide the following core services to juveniles served in juvenile detention centers:

- Emergency;
- Consumer monitoring;
- Assessment and evaluation; or
- Early intervention services.

Child Psychiatry and Children's Crisis Response Services

In its 2011 report to the Virginia General Assembly, entitled "A Plan for Community-Based Children's Behavioral Health Services in Virginia" (Item 304.M.), the Virginia Department of Behavioral Health and Developmental Services (VDBHDS) outlined the comprehensive service array necessary to meet the needs of children with behavioral health problems (VDBHDS, 2017). The service array included crisis response services, which includes mobile crisis and crisis stabilization services. Rural CSBs were particularly challenged in supporting these service models, so a regional approach was proposed to allow the services to be shared among CSBs. Regions experienced the most growth in the number of children who were served by face-to-face psychiatric visits, tele-psychiatry, and psychiatric consultation with pediatricians and primary care physicians. Because the Commonwealth's general fund allocation for these services has increased from $1.5 million in Fiscal Year 2013 to $8.4 million in Fiscal Year 2017, there has been significant growth in the number of children who received mobile crisis and crisis stabilization services. Youth in detention centers are also receiving these services.

Mental Health Services Transition Plans

The following is taken from the Virginia Department of Juvenile Justice (VDJJ) (2010). Developing a mental health transition plan helps with the transition of mental health services for juveniles committed to

VDJJ. In 2005, the Virginia General Assembly enacted legislation requiring the planning and provision of mental health, substance abuse, or other therapeutic treatment services for juveniles who were returning to the community following commitment to a juvenile correctional center or post-dispositional detention. The intent of this requirement was to improve outcomes for juveniles committed to the Department through improved transition planning. The implementation date for these plans was January 2008. All juveniles committed to VDJJ are to be evaluated, at intake, by a qualified mental health professional to determine if they qualify for a mental health services transition plan. Services for identified juveniles are secured prior to their release. For all identified youth, the assigned counselor must schedule a facility eligibility review meeting 90 days prior to the juvenile's release date. This meeting includes the juvenile's legal guardian, probation or parole officer, facility staff knowledgeable about the juvenile's mental health needs, and the juvenile.

Overview for Families

The juvenile brain is not fully mature. For this reason, young people are less able to use good judgment and are more prone to influence from family, school, peers, and community. In addition, stress, peer pressure, and immediate reward are more likely to influence their behavior than the behavior of adults.

Table 3 outlines factors that may make it more or less likely that youth will enter the juvenile justice system. No single risk or protective factor can predict whether a youth will become a juvenile offender. However, reducing risk factors and promoting protective factors may help keep youth out of the juvenile justice system.

Table 3
Factors Affecting Entrance Into the Juvenile Justice System

Risk Factors	Protective Factors
• Substance use • Low grade point average • Aggressive responses to shame • Lack of involved adults in community • Inadequate command of behaviors or high emotional distress • Low IQ or learning difficulties • Disengaged family • Chronic school truancy	• High self esteem • High expectations • Structure and rules at home • Positive attitudes about school rules and law enforcement • Access to adults with whom the child can discuss problems • Involvement in learning • Secure attachment to caregivers • Sense of belonging

Sources: CDC, 2017; Carr and Vandiver, 2001; Research & Training Center on Family Support and Children's Mental Health, 2001; Youth.gov, n.d.

Studies have shown that juvenile offenders are more likely to have mental health disorders. Treating these disorders may help youth overcome other causes of juvenile delinquency. Affected families are encouraged to reach out to community-based services for additional assistance.

Conclusion

Community agencies, such as social services, public school divisions, and the juvenile justice system, frequently serve youth with untreated or under-treated mental health disorders. The juvenile justice system serves those youth whose behavior or actions bring them under the purview of the court. Although juvenile offenders with mental health disorders are a challenging population, promising intervention strategies do exist. However, it is important to remember that, although the juvenile justice system should respond to the mental health needs of youth, the juvenile justice system cannot supplant the mental health

system (Boesky, 2002). To effectively serve juvenile offenders with mental health treatment needs, there should be shared responsibility between the juvenile justice and mental health systems. Services should be gender responsive and should integrate recent advances in trauma-based care. They should also involve families as fully as possible in the treatment of their children (Skowyra & Cocozza, 2006).

Resources and Organizations

American Academy of Child & Adolescent Psychiatry (AACAP)

https://www.aacap.org/

National Center for Juvenile Justice (NCJJ)

http://www.ncjj.org/

National Center for Mental Health and Juvenile Justice (NCMHJJ)

https://www.ncmhjj.com

National Child Traumatic Stress Network

http://www.nctsnet.org/

National Council of Juvenile and Family Court Judges

https://www.ncjfcj.org/

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

https://www.ojjdp.gov

Virginia Resources and Organizations

Virginia Department of Behavioral Health and Developmental Services (VDBDHDS)

http://www.dbhds.virginia.gov/

Virginia Department of Criminal Justice Services (VDCJS)

http://www.dcjs.virginia.gov/

Virginia Department of Juvenile Justice (VDJJ)

http://www.djj.virginia.gov/

References

Abram, K., Teplin, L., McClelland, G., & Dulcan, M. (2003). Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 60*(11), 1097-1108.

American Academy of Child and Adolescent Psychiatry (AACAP). (2013). Systems-based practice juvenile justice system. Retrieved from https://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/training_toolkit_for_systems_based_practice/Systems_Based_Practice_Module_Juvenile_Justice_201406.pdf

American Academy of Pediatrics Committee on Adolescence. (2011). Health care for youth in the juvenile justice system. *Pediatrics, 128*, 1219-1235

American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.) (DSM-IV-TR). Washington, DC: Author.

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.) (DSM-5). Washington, DC: Author.

Boesky, L. (2002). Juvenile offenders with mental health disorders: Who are they and what do we do with them? In *Oppositional Defiant Disorder and Conduct Disorder* (pp. 36-60). Maryland: American Correctional Association.

Carr, M., & Vandiver, T. (2001). Risk and protective factors among youth offenders. *Adolescence, 36*(143), 409-426

Centers for Disease Control and Prevention (CDC). (2017). Youth violence: Risk and protective factors, risk factors for the perpetration of youth violence. Retrieved from https://www.cdc.gov/violenceprevention/youthviolence/riskprotectivefactors.html

Chamberlain, P., & Reid, J. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting Psychology, 66*(4), 624-633.

Chamberlain, P. (1998). Office of Juvenile Justice and Delinquency Prevention. *Treatment foster care.* Washington, DC: OJJDP.

Coalition for Evidence Based Policy. (n.d.). Multisystemic therapy for juvenile offenders. Retrieved from http://evidencebasedprograms.org/1366-2/multisystemic-therapy-for-juvenile-offenders

Coalition for Evidence Based Policy. (n.d.). Treatment Foster Care Oregon (formerly MTFC) – top tier. Retrieved from http://evidencebasedprograms.org/1366-2/multidimensional-treatment-foster-care

Coalition for Juvenile Justice. (2000). Handle with care: Serving the mental health needs of young offenders coalition for juvenile justice. 2000 Annual Report.

Cottle, C., Lee, R., & Heilbrun, K. (2001). The prediction of criminal recidivism in juveniles: a meta-analysis. *Criminal Justice and Behavior, 28,* 367-394.

David-Ferdon, C., Vivolo-Kantor, A. M., Dahlberg, L. L., Marshall, K. J., Rainford, N. & Hall, J. E. (2016). *A comprehensive technical package for the prevention of youth violence and associated risk behaviors*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Farrington, D. P., Ttofi, M. M., & Piquero, A. R. (2016). Risk, promotive, and protective factors in youth offending: Results from the Cambridge study in delinquent development. *Journal of Criminal Justice, 45,* 63-70

Glick, B., & Goldstein, A. (1987). Aggression replacement training. *Journal of Counseling and Development, 65*, 356-362.

Greene, Peters, & Associates. (1998). *Guiding principles for promising female programming: An inventory of best practices.* Washington, DC: U.S. Department of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Grisso, T. (2008). Adolescent offenders with mental disorders. *The Future of Children, 18*(2), 143-164.

Hammond, S. (2007). *Mental health needs of juvenile offenders.* National Conference of State Legislatures. Retrieved from https://www.ncsl.org/print/cj/mentaljjneeds.pdf

Heilbrun, K., Cottle, C., & Lee, R. (2001). Juvenile justice fact sheet: Risk assessment for adolescents. Retrieved from https://www.ncjrs.gov/pdffiles1/191636.pdf

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic therapy for antisocial behavior in children and adolescents* (2nd ed). New York: Guilford.

Henggeler, S. W., & Schoenwald, S. (2011). Evidence-based interventions for juvenile offenders and juvenile justice policies that support them. *Social Policy Report, 25*(1), 1-28.

Kendziora, K. T., & Osher, D. M. (2004). Fostering resilience among youth in the juvenile justice system. In C. S. Clauss-Ehler & M. D. Weist (Eds.), *Community planning to foster resilience in children* (pp. 177-195). New York: Kluwer.

King, D., Abram, K., Romero, E., Washburn, J., Welty, L. & Teplin, L. (2011). Childhood maltreatment and psychiatric disorders among detained youths. *Psychiatric Services, 62*(12), 1430-1438.

Linehan, M., Armstrong, H., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1064.

McCart, M. R., & Sheidow, A. J. (2016). Evidence-based psychosocial treatments for adolescents with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology*, *45*(5), 529-563.

McGarvey, S. C. (2012). Comment, juvenile justice and mental health: Innovation in the laboratory of human behavior, *Jurimetrics*, *53*, 97-120.

Morgan, R. D., Flora, D. B., Kroner, D. G., Mills, J. F., Varghese, F., & Steffan, J. S. (2012). Treating offenders with mental illness: A research synthesis. *Law and Human Behavior*, *36*(1), 37–50.

National Center for Mental Health and Juvenile Justice (NCMHJJ). (2016). *Mental health screening in juvenile justice settings*. Retrieved from https://www.ncmhjj.com/wp-content/uploads/2016/09/Mental-Health-Screening-in-Juvenile-Justice-Settings-for-WEBSITE.pdf

National Center for Mental Health and Juvenile Justice (NCMHJJ). (2002). *Best practice interventions.*

National Center for Mental Health and Juvenile Justice (NCMHJJ). (2005). The MacArthur initiative on mental health and juvenile justice. Retrieved from http://www.ncmhjj.com/projects/macarthur.asp. *Not available December 2017.*

National Center for Mental Health and Juvenile Justice (NCMHJJ). (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study.* Retrieved from https://ncmhjj.com/wp-content/uploads/2013/11/PrevalenceRPB.pdf

National Center for Mental Health and Juvenile Justice (NCMHJJ). (2007). *Trauma among youth in the juvenile justice system: Critical issues and new directions.* Retrieved from https://www.ncmhjj.com/wp-content/uploads/2013/10/2007_Trauma-Among-Youth-in-the-Juvenile-Justice-System.pdf

National Council of Juvenile and Family Court Judges (NCJFCJ). (2014). Massachusetts Youth Screening Instrument (MAYSI)/(MAYSI-2). Retrieved from http://www.ncjfcj.org/massachusetts-youth-screening-instrument-maysimaysi-2

National Mental Health Association (NMHA). (2004). Mental health treatment for youth in the juvenile justice system: A compendium of promising practices. Chicago, IL: MacArthur Foundation.

Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2015). *Risk and needs assessment for youths*. Development Services Group. Retrieved from https://www.ojjdp.gov/mpg/litreviews/RiskandNeeds.pdf

Research & Training Center on Family Support and Children's Mental Health. (2001). Data trends, summaries of research on mental health services for children and adolescents and their families. *Juvenile Justice and Mental Health.*

Schubert, C., Mulvey, E., & Alderfer, A. (2011). Serious juvenile offenders: Do mental health problems elevate risk? Retrieved from http://reclaimingfutures.org/blog/2011/10/05/juvenile-justice-system-mental-health-criminogenic-risk-research-update/

Skowyra, K., & Cocozza, J. (2006). Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system. Delmar, NY: Skowyra and Cocozza.

Snyder, H., & Sickmund, M. (1999). *Juvenile offenders and victims: 1999 national report*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Stoddard-Dare, P., Mallett, C. A., & Boitel, C. (2011). Association between mental health disorders and juveniles' detention for a personal crime. *Child and Adolescent Mental Health, 16,* 208-213.

Sukhodolsky, D., & Ruchkin, V. (2006). Evidence-based psychosocial treatments in the juvenile justice system. *Child and Adolescent Psychiatric Clinics of North America, 15*(2), 501-516.

Sullivan, M. B., Bennear, L. S., Honess, K. F., Painter, W. E., Jr., & Wood, T. J. (2012). Family centered treatment—an alternative to residential placements for adjudicated youth: Outcomes and cost-effectiveness. *OJJDP Journal of Juvenile Justice, 2*(1), 25-40.

Sullivan, M., Bennear, L., & Painter, W. (2009). A *quasi-experimental examination of family centered treatment: Outcomes for a juvenile delinquent population*. Retrieved from http://www.ifcsinc.com/research/A%20Quasi-experimental%20Examination%20of%20FCT%2007.13.2009.pdf. *Not available December 2017.*

Teplin, L. A., Abram, K. M., McClelland, G. M., Mericle, A. A., Dulcan, M. K., & Washburn, J. J. (2006, April). Psychiatric disorders in youth in detention. *OJJDP Juvenile Justice Bulletin.* Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/210331.pdf

Teplin, L., Abram, K., Washburn, J., Welty, L., Hirschfield, J., & Duncan, M. (2013, February). The Northwestern Juvenile Project: Overview. *OJJDP Juvenile Justice Bulletin*. Retrieved from https://www.ojjdp.gov/pubs/234522.pdf

Teplin, L., Abram, K., McClelland, G., Dulcan, M., & Mericle, A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*(1), 1133-1143.

Trupin, E., Stewart, D., Beach, B., & Boesky, L. (2002). Effectiveness of a dialectical behaviour therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health, 7*(3), 121-127.

Underwood, L. A., & Washington, A. (2016). Mental illness and juvenile offenders. *International Journal of Environmental Research and Public Health, 13*(2), 228.

U.S. Department of Health and Human Services. (2004). *Brief strategic family therapy: SAMHSA model program facts sheet.* Rockville, MD: U.S. Substance Abuse and Mental Health Services Administration.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—a supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Vincent, G. M. (2011). *Screening and assessment in juvenile justice systems: Identifying mental health needs and risk of reoffending*. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health.

Virginia Department of Behavioral Health and Developmental Services (VDBHDS). (2017). *Report on funding for child psychiatry and children's crisis response services—Report document no. 325*. Retrieved from https://legsearch.state.va.us/search?site=RGA&client=RGA&output=xml_no_dtd&proxystylesheet=RGA&filter=0&q=report+on+funding+for+child

Virginia Department of Juvenile Justice (VDJJ). (2016). *Data resource guide for fiscal year 2016.* Retrieved from http://www.djj.virginia.gov/pdf/about-djj/DRG/FY16_DRG.pdf

Virginia Department of Juvenile Justice (VDJJ). (2010). *Agency strategic plan for 2010-2012*. Virginia Performs. Retrieved from http://vaperforms.virginia.gov/agencylevel/stratplan/spReport.cfm?AgencyCode=777. *Not available December 2017.*

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). (2009). An integrated policy and plan to provide and improve access to mental health, mental retardation and substance abuse services for children, adolescents and their families. Retrieved from http://www.dbhds.virginia.gov/documents/reports/CFS-330FReport.pdf. Not available December 2017.

Wilson, D., Bouffard, L., & MacKenzie, D. (2005). A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders. *Criminal Justice and Behavior, 32*(2), 172-204.

Youth.gov. (n.d.). Risk & protective factors. Retrieved from https://youth.gov/youth-topics/juvenile-justice/risk-and-protective-factors

Zahn, M. A. (2010). *Causes and correlates of girls' delinquency.* Girls Study Group, Office of Juvenile Justice and Delinquency Prevention. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/226358.pdf

Zajac, K., Sheidow, A. J., & Davis, M. (2015). Juvenile justice, mental health, and the transition to adulthood: A review of service system involvement and unmet needs in the US. *Children and Youth Services Review, 56,* 139-148.

Additional References of Interest

Chamberlain, P. (2003). Treating chronic juvenile offenders: Advances made through the Oregon multidimensional treatment foster care model. Washington, DC: American Psychological Association.

Cocozza, J., & Skowyra, R. (2000). *Youth with mental health disorders: Issues and emerging responses*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. Retrieved from https://files.eric.ed.gov/fulltext/ED442030.pdf

Huber, J., & Wolfson, J. (2000). *Handle with care: Serving the mental health needs of young offenders*. Washington, DC: Coalition for Juvenile Justice. Retrieved from http://www.njjn.org/uploads/digital-library/Summary-of-CJJ-report-on-mental-health--Handle-with-Care.pdf

Schindler, M. (1999). Mental health issues facing adolescents: Part I and Part II. Retrieved from http://www.ylc.org/wp/wp-content/uploads/MentalHealthIssuesinJJSystem.pdf