JUVENILE OFFENDING

Introduction

The responsibility for children's mental health is dispersed across multiple systems: schools, juvenile justice, and child welfare (U.S. Department of Health and Human Services, 1999). Unfortunately, an increasing number of youth with mental health disorders continue to enter, and remain 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 mental health prevalence in youth involved in the juvenile justice system. According to this study, 70 percent of these youth meet the criteria for at least one mental health disorder and approximately 27 percent experience a mental health disorder so severe that they require critical and immediate treatment (NCMHJJ, 2006).

Estimates provided by state and local juvenile justice facilities suggest that juvenile offenders have significant mental health treatment needs. A study of juveniles in detention homes conducted by the Virginia Department of Juvenile Justice (DJJ) showed that more than 40 percent of males and almost 60 percent of females were in need of mental health services; more than seven percent of males and more than 15 percent of females had urgent mental health treatment needs (Virginia Joint Commission for Behavioral Health Care, Virginia State Crime Commission and Virginia Commission on Youth, 2002).

Juveniles entering the justice system typically manifest complex mental health and behavioral health needs. However, a lack of community-based treatments has resulted in youth with mental health disorders being placed in the juvenile justice system for minor and non-violent offenses (NCMHJJ, 2005). According to the National Alliance for the Mentally Ill (NAMI), 36 percent of respondents to a nationwide survey of families having children with severe mental health disorders said that their children were in the juvenile justice system because of the unavailability of mental health care services (1999). Data compiled from national studies reveals that the rate of mental health disorders is higher in youth in the juvenile justice population than in the general population (Otto, Greenstein, Johnson & Friedman, 1992; Teplin, Abram,

McClelland, Dulcan & Mericle, 2002; Wierson, Forehand & Frame, 1992). The psychiatric disorders seen most commonly in juvenile offenders are listed in Table 1.

Table 1

Most Common Mental Health Disorders Seen Among Juvenile Offenders

Conduct Disorder	Attention Deficit Hyperactivity Disorder
Oppositional Defiant Disorder	Posttraumatic Stress Disorder
Major Depressive Disorder	Intellectual Disability
Dysthymic Disorder	Learning Disorders
Bipolar Disorder	Fetal Alcohol Syndrome

Source: Boesky, 2002.

Risk and Protective Factors

Several risk factors are predictive of violent juvenile offending. These include substance use, low grade point average, aggressive responses to shame, unavailability of caring adults in the community, learning difficulties, and weak parental involvement (Hart, O'Toole, Price-Sharp & Shaffer, 2007). Carr and Vandiver (2001) identified the protective factors that were 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, having more positive attitudes toward school rules and law enforcement, and having more structure and rules within their homes. Conversely, the risk factors which have been found to be related to subsequent institutional placement include chronic school truancy, prior outpatient treatment for mental health or substance abuse, and prior use of a firearm (Research & Training Center on Family Support and Children's Mental Health, 2001).

The presence of one or more mental health disorders also serves as a risk factor for juvenile offending, placement within the juvenile justice system, and likelihood of recidivism (Cottle, Lee & Heilbrun, 2001). The findings of a study conducted by the Research & Training Center on Family Support and Children's Mental Health (2001) indicated that children at risk for institutional placement are placed according to the primary type of dysfunction they display, with behaviorally-disordered children becoming incarcerated and emotionally-disordered children being placed into the state mental health system. In addition, the NCMHJJ (2005) identified gender-specific risk factors such that females were found to be at a greater risk of being victims of sexual abuse, which may also influence high-risk behaviors linked to delinquency (Greene, Peters & Associates, 1998). Further, a meta-analysis indicated that specific mental health problems, including conduct problems, anxiety, and other non-severe psychopathology, may also impact the likelihood of subsequent recidivism (Cottle, Lee & Heilbrun).

Assessment

Bartol and Bartol (2008) highlighted several risk assessment instruments which have been used to assess risk for violence and recidivism. The Historical/Clinical/Risk Management Scale (HCR-20; Webster, Harris, Rice, Cormier & Quinsey, 1994) assesses risk for violence among individuals suffering from serious mental health disorders, and has demonstrated good internal

consistency and reliability (Belfrage, 1998), as well as predictive validity in forensic psychiatric settings (Brown, 2001). The Violence Risk Appraisal Guide (VRAG; Harris, Rice & Quinsey, 1993) assesses risk for violence across a long period of time, and has demonstrated predictive validity for violent recidivism across a range of studies (Harris & Rice, 2003). However, the degree of predictive validity is less striking when it is used with offenders suffering from major psychopathology (Grann, Belfrage & Tengstrom, 2000). The Iterative Classification Tree (ICT; Monahan et al., 2001) uses a flowchart format to identify individuals as being at low- or high-risk for violent offending. There is limited research examining the reliability and validity of the ICT, but initial research has found support for the predictive validity (Monahan et al., 2005). The Level of Service Inventory–Revised (LSI-R; Andrews & Bonta, 1995) assesses risk factors for services needed, as well as for reconviction. Previous research has found that the LSI-R demonstrates reliability and validity for assessing risk for recidivism (Loza & Simourd, 1994). Finally, the Psychopathy Checklist–Revised (PCL-R; Hare, 2003) assesses violent behavior and recidivism, and has demonstrated good reliability and predictive validity for general and violent recidivism (Tengstrom, Grann, Langstroem & Kullgren, 2000).

Comorbid Disorders

A high percentage of youth in the juvenile justice system meet the American Psychiatric Association's *Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM IV-TR)* criteria for more than one mental health disorder. Among youth in the juvenile justice system who have a mental health diagnosis, about 70 percent have a co-occurring substance abuse disorder (Skowyra & Cocozza, 2006). Further, 25 percent of youth experience mental health disorders so severe that their ability to function is impaired (Skowyra & Cocozza). Co-occurring mental health and substance abuse problems place distinct demands upon treatment programs and require strong collaboration. Solutions for treating co-occurring 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 abuse.

Evidence-based 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 reoffense by as much as 80 percent (Coalition for Juvenile Justice, 2000).

NCMHJJ has compiled information on treatments for juvenile offenders (2002). These interventions incorporate several treatment components and are discussed in the following paragraphs. These treatment approaches are described by their treatment settings in the paragraphs which follow. Table 2 outlines these treatments as What Works and What Seems to Work.

Home and Community-Based Models

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

Multisystemic Therapy

Multisystemic Therapy (MST) is an integrative, family-based treatment which focuses on improving psychosocial functioning for youth and families with the goal of reducing or

eliminating the need for out-of-home placements. MST addresses the numerous factors shaping serious antisocial behaviors in juvenile offending while focusing on the youth and their family, peers, school, and neighborhood/community support (Henggeler, as cited by the NCMHJJ, 2002). 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 with juvenile populations having emotional and behavioral problems. Evaluations have shown reductions of up to 70 percent in long-term rates of re-arrest and reductions of up to 64 percent in out-of-home placements, along with improvements in family functioning and decreased mental health problems (National Mental Health Association, NMHA [now Mental Health America, MHA], 2004).

Table 2

Summary of Treatments for Juvenile Offenders

What Works	Description
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.
Multidimensional Treatment Foster Care (MTFC)	As an alternative to corrections, MTFC places juvenile offenders who require residential treatment with carefully trained foster families who provide youth with close supervision, fair and consistent limits, consequences, and a supportive relationship with an adult.
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.
What Seems to Work	**Description**
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 in youth.
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.

Source: NCMHJJ, 2002; Sullivan, Bennear & Painter, 2009 (FCT)*.

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. This model allows for intervention in complex problems through clinical practice that is flexibly structured, culturally sensitive, and accountable to families (Sexton and Alexander, as cited by the NCMHJJ, 2002).

FFT focuses on the delinquency problem and on treating youth who exhibit maladaptive and "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).

Multidimensional Treatment Foster Care

Multidimensional Treatment Foster Care (MTFC) 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. It promotes both rehabilitation and public safety (Chamberlain, 1998). During the placement timeframe, the youth's biological or adoptive family is also receiving family therapy to further the goal of returning the youth to that family (NMHA, 2004).

Chamberlain (1998) found that MTFC 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 MTFC, as compared to traditional group care, were more likely to return home to reside with relatives and have less official and self-reported criminality (e.g., violent crimes or delinquent behaviors) (Chamberlain & Reid, 1998).

Family Centered Treatment

A recent treatment approach which shows promise is Family Centered Treatment (FCT). The information in the following paragraph is from the Institute for Family Centered Treatment (Sullivan, Bennear & Painter, 2009).

FCT was developed by Institute for Family Centered Services (IFCS) as an intensive, in-home treatment. The goal of FCT is to keep the 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 has been conducted and found, in the first year following treatment, 23 percent fewer youth were in a residential placements, 16 percent fewer youth in pending placements, 30 percent reduction in length of residential placement, and 11 percent fewer youth in secure detentions. 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 trained professionals and the length and type

vary 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 thoughts and 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, 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 recidivism rates and displaying the positive effects of cognitive restructuring and skills (Wilson, Bouffard & MacKenzie, 2005).

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) was originally validated for use 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's making positive changes, such as development of 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, Stewart, Beach & Boesky, 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 which may lead to behavior problems in youth (U.S. Department of Health and Human Services [HHS], 2004). It includes three therapeutic techniques, including developing a therapeutic alliance with family members, diagnosing the problem behavior(s), and restructuring, or changing family interactions that lead to these problematic 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 (HHS).

Aggression Replacement Therapy

Aggression Replacement Therapy (ART) is a short-term, educational program that focuses on anger management, while providing youth with the skills to decrease antisocial behaviors and to utilize prosocial behaviors. The three main components of ART include 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 the 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 which build upon the strengths of the youth and their family.

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

Sukhodlsky 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, while there may be ample evidence for treating youth with various psychopathologies using the aforementioned treatments, 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.

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 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).

Services in Virginia

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

Juvenile Detention Centers

The information contained in this section is taken from the *Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and their Families* published in 2009 by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services [DMHMRSAS] (now the Virginia Department of Behavioral Health and Developmental Services [DBHDS]).

The Virginia Department of Juvenile Justice (DJJ) estimated that at least 50 percent of Virginia's juvenile detention population was in need of behavioral health services (DMHMRSAS, 2009). The DBHDS and DJJ funded five projects with a combination of federal and state funding to allow Community Service Boards (CSBs) to provide mental health screening, assessment services, and community-based referrals for youths in local juvenile detention facilities. The 2006 General Assembly appropriated $1.14 million for nine additional projects and also covered the federal share of funding for the others, to bring the total number of projects to 14.

These programs, which increase local system capacity to identify and intervene in the lives of children involved in the juvenile justice system, serve approximately 2,500 youth annually and support 23 programs. Programs in operation include:

- Alexandria CSB/Northern VA Detention Home
- Blue Ridge Behavioral Health/Roanoke Detention Center
- Central Virginia CSB/ Lynchburg Detention Center
- Region 10 CSB/Blue Ridge Detention Center
- Chesapeake CSB/Chesapeake Juvenile Justice Center
- Chesterfield CSB/Chesterfield Juvenile Detention Home
- Colonial CSB/Merrimac Detention Center
- Crossroads CSB/Piedmont Juvenile Detention Home
- Danville CSB/W.W. Moore Detention Center
- District 19 CSB/Crater Juvenile Detention Home
- Fairfax-Falls Church CSB/Fairfax Juvenile Detention Home
- Hampton-Newport News CSB/Newport News Juvenile Detention Home
- Henrico CSB/Henrico Juvenile Detention Home
- Loudoun CSB/Loudoun Juvenile Detention Home
- New River Valley CSB/New River Valley Detention Center
- Norfolk CSB/Norfolk Juvenile Detention Home
- Northwestern CSB/Northwestern Juvenile Detention Home
- Planning District One Behavioral health/Highlands Juvenile Detention Home
- Prince William CSB/Prince William Juvenile Detention Home
- Rappahannock CSB/Rappahannock Juvenile Detention Home
- Richmond Behavioral Health/Richmond Juvenile Detention Home
- Valley CSB/Shenandoah Juvenile Detention Center
- Virginia Beach CSB/Virginia Beach Juvenile Detention Home

The following information is from the Virginia Department of Behavioral Health and Developmental Services (P. Fisher, personal communication, April 6, 2010). During the first two quarters of fiscal year 2010, 2,563 youth received a mental health service while in detention. Services include:

- Case management: 459 youth;
- Emergency services: 123 youth;
- Early intervention services: 507 youth; and
- Assessment and evaluation services: 705 youth.

Mental Health Services Transition Plans

The following is taken from the Virginia Department of Juvenile Justice (DJJ) (2010).

> 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. Once this requirement was implemented, all juveniles committed to the Department of Juvenile Justice 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 residents secured prior to 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.

Conclusion

Community agencies, such as social services, public school divisions, and juvenile justice, 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. The juvenile justice system can neither select its service population nor refuse to accept a youth based on mental health diagnosis (Boesky, 2002). 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 the youth, the juvenile justice system cannot supplant the mental health system (Boesky).

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Additional Resources

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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.

Huber, J., & Wolfson, J. (2000). *Handle with Care: Serving the Mental Health Needs of Young Offenders*. Washington, DC: Coalition for Juvenile Justice.

Schindler, M. (January/February 1999). Mental health issues facing adolescents: part I. *AACAP News.*

Schindler, M. (March/April 1999). Mental health issues facing adolescents: part II. *AACAP News.*

Organizations

National Association of Cognitive-Behavioral Therapists
http://www.nacbt.org

Family Centered Treatment
Institute for Family Centered Services, Inc.
757-410-3896
http://ifcsinc.com/standard/page.aspx?guid=779cbe58-f0f1-454e-8cc1-331d00571faa

Functional Family Therapy
206-369-5894
http://www.fftinc.com

Multidimensional Treatment Foster Care
http://www.mtfc.com

Multisystemic Therapy
http://www.mstservices.com

Virginia

Department of Behavioral Health and Developmental Services (DBDHDS)
http://www.dbhds.virginia.gov

Department of Criminal Justice Services (DCJS)
http://www.dcjs.virginia.gov

Department of Juvenile Justice (DJJ)
http://www.djj.virginia.gov