An overview of child and adolescent mental health needs in the juvenile justice system

Carol L. Kessler

Never doubt that a small group of thoughtful committed citizens can change the world; indeed it’s the only thing that ever has.

Margaret Mead

The following pages reflect the dedication of a diverse group of professionals to the needs of an oft neglected population. Youth who become involved with the justice system, by committing delinquent acts and/or status offenses, present with a myriad of issues. It has become increasingly evident that their mental health, educational, and social needs have all too often been inadequately assessed or addressed. Punitive measures and detention create a population of repeat offenders and fail to respond to the root causes of antisocial behavior. With the realization that most justice-involved youth silently suffer from mental health problems, professionals have begun to seriously study both the prevalence of these disorders, and how they might effectively be treated.

We are fortunate to have the contributions of Teplin and colleagues (Chapter 2), who are leaders in an epidemiological approach to psychiatric diagnoses in the juvenile justice population. Their chapter reviews the existing literature, and presents the results of their Northwestern Juvenile Project, which they designed to address limitations of previous research. Prevalence rates of youth in Cook County detention are presented. They indicate high rates of mental illness and of co-morbidity, and point to the need to ensure that youth’s right to care is met. They acknowledge the limitations of their method, which did not include those justice-involved youth who are not detained, and which measured symptomatology shortly after confinement, when distress may partly reflect adjustment reactions. They point to the need for further study of co-morbidity, of justice-involved young women, of the long-term outcome of detained youth, and of pathways from trauma-exposure to the development of posttraumatic stress disorder.

The disproportionate number of minority – African American, Asian American, Latino/Hispanic, Native American – youth confined to detention centers in the United States is the concern of Arroyo (Chapter 3). He reviews current research,
and points to the potential biases at various points along the path of juvenile justice processing. He also reports efforts by the Office of Juvenile Justice and Delinquency Prevention to address discriminatory practices through education, technical assistance, and research. Awareness of the problem of disproportionate minority confinement must be heightened so that its root causes can be further elucidated and addressed.

Redlich and Drizin (Chapter 4) define the interrogation room as a station along the path of juvenile justice processing where youth, especially with mental disorders, are vulnerable to false or coerced confessions and consequent wrongful detention and/or conviction. The specific techniques used by police officers in a global fashion, with young and old alike, are delineated. The authors present research that indicates how young people and those with mental disorders are liable to respond in a self-incriminating manner. They outline the advances that have been made in the handling of child witnesses and victims, and point out that these advances have not been translated to the interrogation process. Young people are at risk due to their concrete thinking and due to their limited knowledge and understanding of the legal system. They are unlikely to request an attorney. The authors point to the need to advocate for electronic recording of interrogations and for training of police in proper guidelines for the interrogation of youth.

Geraghty, Kraus, and Fink (Chapter 5) point to the role that attorneys and mental health professionals might play in advocating for those youth who inadvertently incriminate themselves during interrogation. Psychiatrists and/or psychologists may be enlisted as expert witnesses to determine whether an alleged offender was competent to waive his/her Miranda rights – the right to remain silent; the right to avoid self-incrimination; the right to legal counsel. Furthermore, mental health professionals may assist legal professionals in assessing whether a justice-involved youth is competent to stand trial. Such assessments are critical to ensure youth’s right to a fair trial.

To examine the root causes of behaviors that lead to involvement of youth with the juvenile justice system, Pope and Thomas (Chapter 6) outline a comprehensive list of key factors that influence the development of antisocial acts. They mention genetics, prenatal toxin exposure, temperament, intelligence, and attachment. Later in childhood and adolescence, parenting style, academic achievement, peer relationships, media exposure, and the quality of the surrounding neighborhood become critical. Abuse and exposure to violence are further variables. The authors point to the need to understand how these factors interact with one another, and to determine their longitudinal impact.

Simkin (Chapter 7) focuses more specifically on those risk factors that lead youth toward substance use, an illegal behavior in and of itself. She introduces the notion that early identification of risk factors might lead to the development of
strategies to transform risk into protective factors. Methods of assessing youth’s stage of substance use and readiness for change are reviewed, as well as an overview of existing psychopharmacologic and therapeutic interventions. The need for early intervention and for coordination of services is emphasized.

Early intervention is a critical need to prevent the high rate of suicide amongst justice-involved youth. Studies are limited by their sole focus on detained youth. Smajkic and Clark (Chapter 8) point to the need for consistent suicide prevention policies to be developed and enforced in all detention centers. Early screening of youth, and training of staff could hopefully decrease significantly the loss of young lives, primarily to hanging.

A unique challenge is posed to the juvenile justice system by those youth who have been accused of sexual offenses. Belsky, Myers, and Bober (Chapter 9) present available demographic data regarding the scope of these offenses. They point to risk factors and theories as to how these factors evolve into sexual offending behavior. The particular challenges posed to the justice system by young sexual offenders are explored, as well as various legal strategies that are implemented. Tools to assess youth who sexually offend are presented, in the form of guided interviews, and categorization schemes. Treatment methods are surveyed, with the emphasis on management of a probable lifelong disorder that is frequently co-morbid with other mental illnesses.

The educational needs of justice-involved youth are explored by Closson and Rogers (Chapter 10). They point to deficiencies in the US educational system that lead to youth’s disengagement from school, and consequent risk for involvement in delinquent behavior. Youth with learning disorders or intellectual challenges are at risk for school failure and dropout. Those with mental disorders are at risk of behavioral problems that tend to be reprimanded with suspension or expulsion – i.e., alienation from the school system. Youth who are detained tend not to receive appropriate educational services, and are liable to fall behind academically as a result of their interaction with the justice system. Standards of educational assessment and of individualized planning are presented to provide a map of adequate teaching for justice-involved youth.

Fassler and Harper (Chapter 11), psychiatrist and lawyer, point to the power of cross-discipline communication, as they highlight the contribution of medical, behavioral, and neurological sciences in abolishing the juvenile death penalty in the United States. The United States was one of the last countries to punish juveniles with death. To establish that young people are less culpable, and that a sentence of death would constitute cruel and unusual punishment, legislators relied not only on the emerging societal standard of decency, but more importantly, on the testimony of mental health professionals. These scientists presented evidence from imaging studies, that mature brain development, particularly in
areas of impulse control and foresight, is not achieved until early adulthood. These insights informed groundbreaking legislation that saves children from the sentence of death.

Morris (Chapter 12) comprehensively delineates medical problems that may predispose to antisocial behavior, as well as illnesses that may result from participating in delinquent activity. Youth in contact with the justice system often have neglected their medical and dental health. Morris cites detention as a time when health needs can be assessed and addressed. He points to the need for health screening, physical examinations, treatment, as well as comprehensive planning for follow-up of chronic illnesses.

Means of screening for mental illness amongst justice-involved youth are reviewed by Vincent, Grisso, and Terry (Chapter 13). They emphasize the role of screening in identifying youth at risk of harming self or others, and youth in need of further mental health evaluation. Systematic screening also documents the level of need for mental health services within the juvenile justice system. The distinction between screening and assessment is delineated. Available screening tools are described that are intended for widespread implementation with minimal resources.

Ruth Kraus (Chapter 14) focuses on assessment tools utilized by psychologists to perform more thorough assessments of each youth’s strengths and weaknesses that might inform an individualized treatment plan. She notes that there is a high incidence of neuropsychological deficits amongst juveniles in the juvenile justice system. Areas of executive functioning and verbal ability tend to be particularly compromised. These deficits likely contribute to poor academic functioning and consequent predisposition to delinquent behavior. Comprehensive assessment of cognitive functioning, intelligence, executive functioning, academic achievement, personality, language skills, and adaptive functioning would provide invaluable information that might tailor behavioral, educational, and psychiatric interventions to each youth’s level of functioning.

Karnik, Soller, and Steiner (Chapter 15) provide an overview of psychopharmacologic treatment for youth offenders, and advocate for the use of medication only after a timely medical, psychiatric, and psychological assessment. Medication is seen as one tool that must be part of an integrated treatment plan. The chapter on psychopharmacology delineates acute or chronic aggression as a frequent target symptom; yet, medications aimed at a primary psychiatric disorder are the goal. It is recognized that it is often difficult to discern whether psychiatric problems have predisposed to delinquency, or have arisen as a result of detention. Risks and benefits must constantly be reassessed and weighed. Psychopharmacologic recommendations are based on clinical trials, and on practice guidelines, where they are available. However, the authors point to the need to establish evidence-based
psychopharmacologic care for the disorders that are just recently being described amongst justice-involved youth.

Evidence-based psychotherapeutic care is the focus of Trupin (Chapter 16). They outline treatment strategies with documented efficacy that target risk factors as well as systemic and behavioral issues of youth and families. Both empirically supported and promising treatment programs are described at the level of prevention, community-based treatment, and transition from detention to aftercare. These programs are depicted via clinical vignettes; their strengths and weaknesses are identified. Treatment modalities include diversion programs, mentoring programs, multisystemic therapy, functional family therapy, and multidimensional therapeutic foster care. The authors point to key components of effective treatment programs, and they emphasize the need for legislative support and funding to translate evidence-based treatment interventions into a therapeutic reality for youth, their families, and their communities.

Thomas (Chapter 17) further emphasizes the promise of community alternatives to incarceration. He provides a historical context, and reviews existing meta-analyses of interventions with justice-involved youth. Evidence is provided that structured treatment modalities of sufficient duration can be effective in community-based work with youth who have committed serious, multiple offenses. Thomas also identifies popular programs that have been shown to have a negative impact, by increasing recidivism rates. He describes community-based multiagency programs, including his own Galveston Island Youth Program, whose outcome studies serve to justify the goal of community-based rehabilitation.

This writer – Kessler (Chapter 18) – describes creative means of transforming the adjudication process into a therapeutic experience. Court and mental health professionals leave their islands to develop a multidisciplinary team approach to justice-involved youth. The judge is at the center, and holds both youth and service providers accountable to the implementation of individualized treatment plans that strive to be developmentally appropriate, culturally sensitive, and gender specific. Plans emerge only after a comprehensive assessment that addresses both legal and clinical needs. Successful team functioning across disciplines depends on consistent cross-training. Implementation of plans depends on the existence of effective community-based systems of care. Alternatives to traditional adjudication – youth court; juvenile drug court; juvenile mental health court – aim to embody restorative, rather than punitive, justice. The goal is to restore right-relationship of youth with themselves, their families, and their communities.

Ethical principles of right-relationship that arise in the course of evaluation and treatment of justice-involved youth are the focus of Romero-Bosch and Penn (Chapter 19). They point to the need for clarity of role when a mental health professional enters into a relationship with a young offender. The need to
distinguish between forensic evaluator and treating clinician is critical. The authors address youth’s right to consent to or to refuse evaluation and/or treatment, and the issue of competency. The tension between a young person’s right to confidentiality and a parent’s right to know is explored. The notion of a young person’s right to care for a mental illness in the least restrictive setting is introduced. The need for clear delineation of appropriate indications for seclusion and/or restraint is also emphasized.

Whereas Romero-Bosch and Penn (Chapter 19) highlight the boundaries of the relationship between forensic mental health evaluator and youth offender, Louis Kraus and Sobel (Chapter 20) outline the content of a post-adjudicatory evaluation. They point to the critical role mental health professionals have in educating the court regarding youth’s mental health needs, and in providing recommendations for appropriate disposition. The post-adjudicatory evaluation ideally consists of interactions not only with the youth, but also teachers and family members. Relevant data concerning previous delinquent behavior, police reports, school records, educational and psychiatric evaluations, and clinic records need to be carefully reviewed. Referrals may need to be made for educational or psychological testing. The evaluator will be expected to provide both a sense of the youth’s risk of harm to the community, as well as recommendations for appropriate means of addressing educational, vocational, and mental health needs. Kraus and Sobel (Chapter 20) point to community-based treatment as the most promising, though often unavailable due to inadequate funding.

This volume indicates the broad range of mental health needs present within those youth who present to the juvenile justice system. It points to strategies for screening and for assessing mental health issues, and it also indicates emerging evidence-based treatment interventions. The need for ongoing collaboration across disciplines – legal, correctional, educational, psychiatric – is evident. For paths toward rehabilitation and reintegration to be forged, and for knowledge to be translated into effective interventions, communities must commit resources to these at-risk youth.
Psychiatric disorders of youth in detention

Linda A. Teplin, Karen M. Abram, Gary M. McClelland, Amy A. Mericle, Mina K. Dulcan, Jason J. Washburn, and Shiraz Butt

The juvenile justice system faces a significant challenge in identifying and responding to the psychiatric disorders of detained youth. In 2003, over 96,000 juvenile offenders were in custody in juvenile residential placement facilities (Sickmund et al., 2006). Despite the difficulty of handling such youth, providing them with psychiatric services may be critical to breaking the cycle of recidivism.

A comprehensive understanding of the prevalence of psychiatric disorders among juvenile detainees is an important step toward meeting their needs. Like adult prisoners, juvenile detainees with serious mental disorders have a constitutional right under the 8th and 14th Amendments to needed services (American Association of Correctional Psychology, 2000; The President’s New Freedom Commission on Mental Health, 2005; Soler, 2002; Costello & Jameson, 1987). Without sound data on the prevalence of psychiatric disorders, however, defining the best means to use and enhance the juvenile justice system’s scarce mental health resources is difficult.

Prior research

Although epidemiological data are key to understanding the psychiatric disorders of juvenile detainees, few empirical studies exist. Table 2.1 lists studies published in the United States since 1990 that examined the diagnostic characteristics of incarcerated and detained juveniles. These studies do not provide data that are comprehensive enough to guide juvenile justice policy. For example, although six studies present rates of multiple disorders, only four of those examine patterns of psychiatric comorbidity among juvenile detainees (Domalanta et al., 2003; Duclos et al., 1998; Pliszka et al., 2000; Shelton, 2001). Furthermore, the results of the studies presented in Table 2.1 are inconsistent. For example, the prevalence of affective disorder in the studies varied from 5 percent (McCabe et al., 2002) to 72 percent (Timmons-Mitchell et al., 1997); substance use disorders from 20 percent (Atkins et al., 1999).
Table 2.1. Published studies of psychiatric disorders in incarcerated, detained, and/or secured juvenile populations in the US, since 1990.

<table>
<thead>
<tr>
<th>Authors, year</th>
<th>Sample</th>
<th>Diagnostic measures</th>
<th>Major findings $^b$</th>
</tr>
</thead>
</table>
| Davis et al., 1991 | Participants: Youth in a state residential facility  
N: 173  
Age: N/R  
Sex: N/R  
Race/ethnicity: "... fairly equally divided between white and non-white ..." (p. 7). | Clinical interview (DSM-III-R criteria) | Affective: Dysthymia: 17%; MDD: 15%  
SUD/AUD: Alcohol Abuse Disorder: 34.1%; Alcohol Dependence Disorder: 12%; Drug Abuse Disorder: 45%; Drug Dependence Disorder: 19%  
CD: 81%  
Other: ADD: 19%; Adjustment Disorder: 18%; Any Developmental Disorder: 17%; Any PD: 17%; ODD: 5% |
| Forehand et al., 1991 | Participants: Youth in a juvenile prison  
N: 52  
Age: 16 years (mean)  
Sex: all males  
Race/ethnicity: African American: 63.4%; White: 36.5% | DISC-2 | Affective: MDD: 33%  
CD: Group Delinquency: 58%; Solitary Aggression: 23%  
Anxiety: Overanxious: 40%  
Other: ADD: 27% |
| Eppright et al., 1993 | Participants: Youth in a juvenile detention center  
N: 100  
Age: 14.6 years (mean)  
Sex: 21 females; 79 males  
Race/ethnicity: African American: 32%; White: 68% | DICA-R; SCID-II | CD: 87%  
<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>K-SADS-PL (additional items added for DSM-III-R criteria)</th>
<th>Affective:</th>
<th>SUD/AUD:</th>
<th>CD:</th>
<th>Anxiety:</th>
<th>Other:</th>
</tr>
</thead>
</table>
| Rohde et al., 1997 | Youth in a secure detention facility | N: 60  
Age: 14.9 years (mean)  
Sex: 16 females; 44 males  
Race/ethnicity: African American: 1.7%; Asian/Pacific Islander: 1.7%; Hispanic: 6.8%; Native American: 5.1%; White: 83.1%; other: 1.7% | Dysthymia: 8%  
MDD: 40%  
SUD/AUD:  
Alcohol Abuse: 7%  
Alcohol Dependence: 42%  
Hard Drug Abuse: 7%  
Hard Drug Dependence: 33%  
Marijuana Abuse: 5%  
Marijuana Dependence: 43% | Alcohol Abuse: 2%  
Alcohol Dependence: 18%  
Hard Drug Abuse: 2%  
Hard Drug Dependence: 17%  
Marijuana Abuse: 3%  
Marijuana Dependence: 23% | CD: 73%  
Anxiety: 18% | ADHD: 17%  
ODD: 17% | 20% met "partial criteria" for PTSD; 31.7% met full criteria for PTSD. |
| Steiner et al., 1997 | Violent incarcerated youth | N: 85  
Age: 16.6 years (mean)  
Sex: all male  
Race/ethnicity: African American: 37.6%; Hispanic: 26.9%; White: 30.1%; other: 5.4% | Psychiatric Diagnostic Interview-Revised |  
Anxiety: 20% met "partial criteria" for PTSD; 31.7% met full criteria for PTSD. |
<table>
<thead>
<tr>
<th>Authors, year</th>
<th>Sample</th>
<th>Diagnostic measures</th>
<th>Major findings^b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timmons-Mitchell et al., 1997</td>
<td>Participants: Institutionalized delinquents</td>
<td>DISC (modified)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N: 50</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age: females: 15.7 years; males: 15.9 years (means)</td>
<td></td>
<td>Psychosis: 16%</td>
</tr>
<tr>
<td></td>
<td>Sex: 25 females; 25 males</td>
<td></td>
<td>Affective: 72%</td>
</tr>
<tr>
<td></td>
<td>Race/ethnicity:</td>
<td></td>
<td>SUD: 88%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CD: 100%</td>
</tr>
<tr>
<td></td>
<td>Other: 50 subjects were administered the DISC out of the total sample of 173 subjects.</td>
<td></td>
<td>Anxiety: 52%</td>
</tr>
<tr>
<td>Cauffman et al., 1998</td>
<td>Participants: Incarcerated wards</td>
<td>Psychiatric Diagnostic Interview-Revised (PTSD module only)</td>
<td>Anxiety:</td>
</tr>
<tr>
<td></td>
<td>N: 189</td>
<td>PTSD:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age: females: 17.2 years; males: 16.6 years (mean)</td>
<td>Eating Disorder:</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Sex: 96 females; 93 males</td>
<td>Sleep Disorder:</td>
<td>68%</td>
</tr>
<tr>
<td></td>
<td>Race/ethnicity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Males: 37.6% African American</td>
<td>ADHD:</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>26.9% Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>30.1% White</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.4% Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females: 21.1% African American</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>28.9% Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23.3% White</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>26.7% Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>