

Intersection between Mental Health and the Juvenile Justice System

Mental health disorders are prevalent among youths in the juvenile justice system. A meta-analysis by Vincent and colleagues (2008) suggested that at some juvenile justice contact points, as many as 70 percent of youths have a diagnosable mental health problem. This is consistent with other studies that point to the overrepresentation of youths with mental/behavioral health disorders within the juvenile justice system (Shufelt and Coccozza 2006; Meservey and Skowyrza 2015; Teplin et al. 2015). However, prevalence varies depending on the stage in the justice system at which youths are assessed. In a nationwide study, the prevalence of diagnosed disorders increased the further that youths were processed in the juvenile justice system (Wasserman et al. 2010).

While there appears to be a prevalence of youths with mental health issues in the juvenile justice system, the relationship between mental health problems and involvement in the system is complicated, and it can be hard to disentangle correlational from causal relationships between the two (Shubert and Mulvey 2014).

This literature review will focus on the scope of mental health problems of at-risk and justice-involved youths; the impact of mental health on justice involvement as well as the impact of justice involvement on mental health; disparities in mental health treatment in the juvenile justice system; and evidence-based programs that have been shown to improve outcomes for youths with mental health issues.

Defining Mental Health and Identifying Mental Health Needs

Defining Mental Health. According to the U.S. Department of Health and Human Services, mental health includes a person's psychological, emotional, and social well-being and affects how a person feels, thinks, and acts. Mental disorders relate to issues or difficulties a person may experience with his or her psychological, emotional, and social well-being. As Stein and colleagues explained, "each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (2010, 1).

The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* is a standard classification tool for mental disorders used by many mental health professionals in the United States (American Psychiatric Association 2013). It includes 20 chapters of mental health disorders, including the following:

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<https://www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf>

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- Substance-related and addictive disorders
- Bipolar and related disorders
- Depressive disorders
- Anxiety disorders
- Obsessive-compulsive disorders
- Trauma- and stressor-related disorders such as posttraumatic stress disorder and adjustment disorders
- Disruptive, impulse control, and conduct disorders
- Neurodevelopmental disorders, which includes intellectual disabilities,¹ attention deficit/hyperactivity disorder, and autism spectrum disorders

A broader categorization divides mental health disorders into two categories: internalizing and externalizing. *Internalizing disorders*, which are negative behaviors focused inward, include depression, anxiety, and dissociative disorders. *Externalizing disorders* are characterized by behaviors directed toward a youth's environment and include conduct disorders, oppositional defiant disorder, and antisocial behaviors.

Tools to Identify Mental Health Needs. Juvenile justice systems use a variety of tools to identify mental health needs, although most fall into one of two categories:

- **Screening.** The purpose of screening is to identify youths who might require an immediate response to their mental health needs and to identify those with a higher likelihood of requiring special attention (Vincent 2012). It is similar to a triage process in a hospital emergency room. Although there are numerous screening instrument options, two commonly used are the Massachusetts Youth Screening Instrument—Version 2 (MAYSI-2; Grisso and Barnum 2006) and the Diagnostic Interview Schedule for Children (Wasserman, McReynolds, Fisher, and Lucas 2005). In addition to tools that screen for multiple mental health-related issues, there are also tools that screen for specific problems, such as the Children's Depression Inventory (Kovacs 1985) or the Suicidal Ideation Questionnaire (Reynolds 1988), which can help determine if a youth should be monitored for suicide attempts upon entry to detention or residential facility.
- **Assessment.** The purpose of assessment is to gather a more comprehensive and individualized profile of a youth. Assessment is performed selectively with those youths with higher needs, often identified through screening. Mental health assessments tend to involve specialized clinicians and generally take longer to administer than screening tools (Vincent 2012). There are numerous mental health assessments. One widely studied assessment is the Achenbach System of Empirically Based Assessment (Achenbach and Rescorla 2001), which includes three instruments completed by youths (Youth Self-Report), parents (Child Behavior Checklist), or teachers (Teachers Report Form)².

Scope of the Problem

Multiple studies confirm that a large proportion of youths in the juvenile justice system have a diagnosable mental health disorder. Studies have suggested that about two thirds of youth in detention or correctional settings have at least one diagnosable mental health problem, compared with an

¹ A separate *Model Programs Guide* literature review on intellectual/development disabilities among youths in the justice system can be accessed here: <https://www.ojjdp.gov/mpg/litreviews/Intellectual-Developmental-Disabilities.pdf>

² For more information on Risk/Needs Assessments for Youths, please see the literature review on the *Model Programs Guide*: <https://www.ojjdp.gov/mpg/litreviews/RiskandNeeds.pdf>

estimated 9 to 22 percent of the general youth population (Schubert and Mulvey 2014; Schubert, Mulvey, and Glasheen 2011). The 2014 National Survey on Drug Use and Health found that 11.4 percent of adolescents aged 11 to 17 had a major depressive episode in the past year, although the survey did not provide an overall measure of mental illness among adolescents (Center for Behavioral Health Statistics and Quality 2015). Similarly, a systematic review by Fazel and Langstrom (2008) found that youths in detention and correctional facilities were almost 10 times more likely to suffer from psychosis than youths in the general population.

These diagnoses commonly include behavior disorders, substance use disorders, anxiety disorder, attention deficit/hyperactivity disorder (ADHD), and mood disorders (Chassin 2008; Gordon and Moore 2005; Shufelt and Coccozza 2006; Teplin et al. 2003). The prevalence of each of these diagnoses, however, varies considerably among youths in the juvenile justice system. For example, the Pathways to Desistance study (which followed more than 1,300 youths who committed serious offenses for 7 years after their court involvement) found that the most common mental health problem was substance use disorder (76 percent), followed by high anxiety (33 percent), ADHD (14 percent), depression (12 percent), posttraumatic stress disorder (12 percent), and mania (7 percent) (Schubert, Mulvey, and Glasheen 2011; Schubert and Mulvey 2014). A multisite study by Wasserman and colleagues (2010) across three justice settings (system intake, detention, and secure post-adjudication) found that over half of all youths (51 percent) met the criteria for one or more psychiatric disorders. Specifically, one third of youths (34 percent) met the criteria for substance use disorder, 30 percent met the criteria for disruptive behavior disorders, 20 percent met the criteria for anxiety disorders, and 8 percent met the criteria for affective disorder.

Many of these youths are also diagnosed with multiple disorders. For example, the Pathways to Desistance study found that 39 percent of youths met the threshold for more than one mental health problem (Schubert, Mulvey, and Glasheen 2011). Similarly, the Northwestern Juvenile Project (a longitudinal study that followed over 1,800 youths who were arrested and detained in Cook County, Illinois) found that 46 percent of males and 57 percent of females had two or more psychiatric disorders (Teplin et al. 2013). In a study of youths in contact with the juvenile justice systems (including community-based programs, detention centers, and secure residential facilities), in Texas, Louisiana, and Washington, Shufelt and Coccozza (2006) found that 79 percent of the youths diagnosed for one mental health disorder also met the criteria for two or more diagnoses.

Impact of Mental Health Problems on Juvenile Justice Involvement

As previously mentioned, the relationship between mental health problems and involvement in the juvenile justice system is complex. As Schubert and Mulvey explained, “although these two problems often go hand in hand, it is not clear that one causes the other. Many youths who offend do not have a mental health problem, and many youths who have a mental health problem do not offend” (2014, 3). There has been research to show how mental health diagnoses and problem behaviors are associated with each other. But as is often emphasized, correlation does not mean causation. In addition, certain risk factors could increase the occurrence of both mental health and problem behaviors in youths. For example, exposure to violence can increase mental health issues, such as posttraumatic stress, in youth and increase the occurrence of delinquent behavior (Finkelhor et al. 2009). However, although the research can point to a relationship between mental health issues and juvenile justice involvement, it remains difficult to determine the exact correlation.

Research on individual risk factors often focuses on how certain mental health problems may be associated with delinquency, violence, and justice system involvement. Researchers have found that some externalizing disorders (e.g., conduct disorders, oppositional defiant disorder, and antisocial

behaviors) and substance use disorders do increase the likelihood of delinquency, violence, and contact with the justice system (Barrett et al. 2014; Hawkins et al. 2000; Huizinga et al. 2000).

For instance, in their meta-analysis of predictors of youth violence, Hawkins and colleagues (2000) found evidence that psychological factors—such as aggression, restlessness, hyperactivity, concentration problems, and risk taking—were consistently correlated with youth violence. However, they also found that internalizing disorders—such as worrying, nervousness, and anxiety—were either unrelated to later violence or reduced the likelihood of engaging in later violence. A recent meta-analysis by Wibbelink and colleagues (2017) also examined the relationship between mental disorders (including internalizing, externalizing, and comorbid disorders) and recidivism in juveniles. Similar to the findings from the Hawkins and colleagues (2000) meta-analysis, Wibbelink and colleagues (2017) found that externalizing disorders were significantly related to recidivism, while internalizing behaviors were not related to recidivism (and in some cases, internalizing behaviors had a buffering effect on recidivism).

This link between certain mental health problems and delinquency has also been studied for youths in certain subpopulations. Among maltreated youths living in out-of-home care, the presence of a mental health disorder was significantly associated with juvenile justice system involvement, and conduct disorder was the strongest predictor (Yampolskaya and Chuang 2012). A study of psychiatric-inpatient adolescents found that having a disruptive disorder, a history of aggressive behavior, and using cocaine were all predictors of juvenile justice system involvement (Cropsey, Weaver, and Dupre 2008).

Trauma or exposure to violence may also increase the likelihood of juvenile justice involvement. Multiple studies show a connection between childhood violence exposure and antisocial behavior, including delinquency, gang involvement, substance use, posttraumatic stress disorder, anxiety, depression, and aggression (Wilson, Stover, and Berkowitz 2009; Finkelhor et al. 2009). In the Northwestern Juvenile Project, 92.5 percent of detained youths reported at least one traumatic experience, and 84 percent reported more than one (Abram et al. 2013). Other studies that have looked at past traumatic exposures in juvenile justice populations have also found high rates (e.g., Romaine et al. 2011; Rosenberg et al. 2014).

Impact of Justice System Involvement on Mental Health Problems

Entry into the juvenile court system may exacerbate youths' existing mental health problems for many reasons. For instance, there is inconsistency across some of the decision points of the juvenile justice system (including in the court systems and residential facilities) in providing referrals to treatment and appropriately screening, assessing, and treating juveniles with mental health conditions. There are also the difficulties that many juveniles face when detained or incarcerated, the increased odds of recidivating once youths are involved in the justice system, and the perceived barriers to services that can prevent youths from seeking or receiving treatment (National Mental Health Association 2004).

Lack of Referrals for Treatment. Among youths involved in the juvenile justice system (including those who have been referred to court or those who have been adjudicated and placed in a residential facility), only a small percentage of those in need of services can access treatment. For example, a 2014 juvenile residential facility census found that 58 percent reported they evaluated all youths for mental health needs, 41 percent evaluated some but not all youths, and 1 percent did not evaluate any youths (Hockenberry, Wachter, and Sladky 2016). However, it is unknown how many of the evaluated youths received referrals for treatment. In a study of juvenile courts in Tennessee, Breda (2003) found that fewer than 4 percent of juveniles who had committed offenses (regardless of diagnosis) were referred for mental health services. A study of a southern California correctional facility also found that only 6

percent of youths were referred for mental health services (Rogers et al. 2001).

Even among youths who have been diagnosed, treatment is not guaranteed. The Pathways to Desistance Project found overall low rates of services provided to youths; however, this depended on both the type of facility in which youths had been placed (i.e., state-run juvenile corrections facilities, contract residential settings, detention centers, and jails/prisons) and the diagnosable mental health issue (Schubert and Mulvey 2014). Similarly, the Northwestern Juvenile Project found that only 15 percent of youths diagnosed with psychiatric disorders and functional impairment received treatment while in detention (Teplin et al. 2013). A study of mental health delivery patterns in Maryland found that only 23 percent of the youths diagnosed with a mental disorder received any treatment (Shelton 2005). A national study found that even if juvenile justice facilities reported having the capacity to provide services to youths in their care, youths with a severe mental health disorder often did not receive any emergency mental health services (Shufelt and Coccozza 2006). Finally, numerous studies have revealed disparities in regard to which youths are more likely to be referred for treatment (see Disparities in Mental Health Treatment below for more information).

Impact of Detention/Confinement. Juvenile detention and correctional facilities may impact youths with mental health issues due to overcrowding, lack of available treatment/services, and separation from support systems (such as family members and friends). In addition, for juveniles in correctional facilities, being placed in solitary confinement or restrictive housing also has the potential to worsen mental health issues (National Institute of Justice 2016).

Greater Likelihood of Recidivism. Given the aforementioned limitations of the juvenile justice system, having a mental health problem while involved in the system can increase youths' likelihood of recidivating or engaging in other problem behavior (e.g., Yampolskaya and Chuang 2012). This link has been documented most frequently for externalizing disorders (Barrett et al. 2014; Constantine et al. 2013; McReynolds, Schwalbe, and Wasserman 2010) and for substance use disorders (Baglivio et al. 2014; Hovee et al. 2013; Schubert and Mulvey 2014).

For example, in their study of Florida youths who had completed juvenile justice residential placements, Baglivio and colleagues (2014) found that current substance use was a predictor of re-arrest. In their study of youths who were previously placed in a detention facility, Mallett and colleagues (2013) found that having a conduct disorder diagnosis and a self-reported previous suicide attempt predicted subsequent recidivism to detention placement. In their study of almost 100,000 youths whose cases had been processed by the South Carolina Department of Juvenile Justice, Barrett and colleagues (2014) found that an early diagnosis of an aggressive disorder was the strongest predictor of recidivism.

Perceived Barriers to Treatment among Youth. Abram and colleagues (2015) surveyed youths with alcohol, drug, and mental health disorders in detention and found that the most frequently cited barrier to services was that youths believed their problems would go away without getting any help. Other reported perceived barriers were that youths were unsure whom to contact or where to go for help, and believed it was too difficult to obtain help. Perceived barriers can impact whether youths pursue treatment in the first place, as well as whether they participate and remain in treatment (Abram et al. 2015).

Disparities in Mental Health Treatment in the Juvenile Justice System

Researchers have also found disparities—particularly by race/ethnicity, gender, and age—in who is

referred for treatment in the juvenile justice system.

Race/Ethnicity. Racial disparities exist among mental health diagnoses and treatment in both the community and the juvenile justice system. In the community, researchers have found that youths of color are less likely to receive mental health or substance use treatment (Dembo et al. 1998; Garland et al. 2005). Researchers have also found that minority youths receive fewer services than white youths in the foster care and child welfare populations (Garland and Besinger 1997; Horwitz et al. 2012). Among youths being served by mental health systems, youths of color are more likely to be referred to the juvenile justice system than white youths (Cauffman et al. 2005; Evens and Vander Stoep 1997; Scott, Snowden, and Libby 2002; Vander Stoep, Evens, and Taub 1997).

Once in the juvenile justice system, minority youths are less likely to be treated for mental health disorders than white youths (e.g., Dalton et al. 2009; Herz 2001; Rawal et al. 2004). According to a 2016 systematic review of articles that examined racial disparities among referrals to mental health and substance abuse services from within the juvenile justice system, most of the studies published from 1995 to 2014 found that there was at least some race effect in determining which youths received services, even when including statistical controls for mental health or substance use diagnosis or need (Spinney et al. 2016).

For example, an examination of detained youths in Indiana found that both African American and Hispanic youths were less likely than white youths to receive contact with a mental health clinician within 24 hours of detention center intake and to receive a referral to mental health services upon detention center discharge—even after incorporating statistical controls for age, gender, detention center site, and whether the youth had a positive MAYSI-2 screening (Aalsma et al. 2014). Additionally, in a study of mental health delivery patterns in the Maryland juvenile justice system, Shelton (2005) found that while 42.6 percent of white youths who met diagnostic criteria received mental health services, only 11.9 percent of the African American youths who met diagnostic criteria received these services. She concluded that the data reflected a racial bias in the provision of services.

Gender-Related Factors. As the proportion of girls involved in the juvenile justice system grows (Espinosa, Sorensen, and Lopez 2013; Odgers et al. 2005), researchers are increasingly looking at how gender differences impact the receipt of mental health care within the system. They are reporting a higher rate of referrals for females than males overall (Teplin et al. 2003; Cauffman et al. 2007; Fazel and Langstrom 2008; Herz 2001). In a study on juvenile offenders in Texas, Daurio (2009) found that girls were more likely than boys to receive mental health placements than incarceration, as a disposition outcome. Gunter-Justice and Ott (1997) also found that family court judges recommended mental health placements more frequently for girls, compared with boys. Once within the system, girls are also more likely to be referred for treatment by facility staff, which, as Rogers and colleagues (2001) suggested, may have to do with the staff members themselves being female. Finally, although girls in the juvenile justice system are referred for mental health treatment more frequently than boys, they are usually not referred for further follow-up treatment upon community reentry (Aalsma, Schwartz, and Perkins 2014).

The following differences between boys and girls may explain why gender is a significant predictor of mental health placement:

1. Girls are most often detained for status offenses and technical violations.
2. Girls report mental health symptoms and are more willing to use psychiatric services than boys.

3. Girls are more likely to exhibit internalizing disorders—such as anxiety, depression, and suicidality—than externalizing disorders such as aggression, bullying, and oppositional behaviors (Huizinga et al. 2000; Espinosa et al. 2013; Teplin et al. 2006).

Ogders and colleagues (2005) also found that the rates of comorbidity of disorders increase exponentially for girls in the juvenile justice system. Regardless of their higher levels of referral as compared with boys, girls are still undertreated in the system given their high need (Espinosa et al. 2013).

Age-Related Factors. Age is often a determinant for who receives mental health services within the juvenile justice system. As various studies have indicated, younger juveniles (usually under 15 years of age) are more likely to be referred for mental health placements (Herz 2001; Daurio 2009). Rogers and colleagues (2001) found that of the youths in a Southern California juvenile correctional facility, those who had been arrested before the age of 14 were more likely to have been referred for treatment than youths arrested after the age of 14. Herz (2001) posited that this referral disparity indicates evidence of a “two-tiered system,” in which older adolescents receive a more punitive than rehabilitative approach than younger adolescents.

Outcome Evidence

Some programs and treatment approaches for justice-involved youths, particularly those involving cognitive-behavioral therapy (CBT), have shown positive results. CBT is designed to help youths adjust their thinking and behaviors related to delinquency, crime, and violence (Little 2005; Beck 1999). CBT programs have also been shown to be effective in reducing recidivism rates (Jeong, Lee, and Martin 2014). Research on other program types that specifically target youths with mental health needs, such as mental health diversion initiatives, have also shown positive results (Colwell, Villarreal, and Espinosa 2012; Cuellar, McReynolds, and Wasserman 2006).

The following are examples of evidence-based programs from the *Model Programs Guide* that have demonstrated positive outcomes for youths with specific mental health needs, the first two of which specifically draw on the strategies of CBT.

Functional Family Therapy. Functional family therapy (FFT) is a family-based prevention and intervention program for high-risk youths ages 11–18. It concentrates on decreasing risk factors and increasing protective factors that directly affect adolescents who are at risk for delinquency, violence, substance use, or behavioral problems such as conduct disorder or oppositional defiant disorder. FFT is conducted over 8–12, 1-hour sessions for mild cases; it includes up to 30 sessions of direct service for families in more difficult situations. Sessions generally occur over a 3-month period and can be held in clinical settings as an outpatient therapy model or as a home-based model.

In one large-scale study on FFT, which was delivered by community-based therapists, Sexton and Turner (2010) found that when adherence to the FFT model was high, FFT resulted in a significant reduction in felony crimes and violent crimes and a nonsignificant decrease in misdemeanor crimes. In addition, a study by Celinska and colleagues (2013) found that FFT had a positive effect on youths in the areas of reducing risk behavior, increasing strengths, and improving functioning across key life domains.

Multisystemic Therapy. Multisystemic Therapy (MST) is designed to help adolescents ages 12–17 who have exhibited serious clinical problems such as drug use, violence, and severe criminal behavior. Through intense family involvement, MST aims to assess the origins of adolescent behavioral problems and change the youth’s ecology to increase prosocial behavior while decreasing problem and delinquent behavior. MST typically uses a home-based model of service delivery to reduce barriers that

keep families from accessing services. The average treatment occurs over approximately 4 months, although there is no definite length of service, with multiple therapist–family contacts occurring each week.

In one evaluation of MST, Henggeler and colleagues (1992) found that, at 59 weeks post-referral, the group that received MST had just more than half the number of re-arrests than the comparison group, which received treatment as usual. Another study showed significant differences between treatment and comparison groups 4 years after the end of their probation: 71.4 percent of the individual therapy comparison group participants were arrested at least once, compared with 26.1 percent of MST participants (Borduin et al. 1995).

Jefferson County Community Partnership. The Jefferson County Community Partnership in Birmingham, Ala., offers services for youth with serious emotional disturbances, which are accessible, community-based, individualized, culturally competent, and include an individual’s family in the planning and delivery of treatment. Overall, the goal of this collaborative approach is to reduce youths’ contact with the juvenile justice system. This includes reducing the odds of future offending and decreasing the seriousness of offenses, if they were committed (Matthews et al. 2013). The Jefferson County Community Partnership is not a program; rather, it is a collaborative framework that operates within a system-of-care concept. An evaluation of the Jefferson County Community Partnership found a significant reduction in contact with the juvenile justice system among youths in the Birmingham system-of-care community, compared with the comparison community (Matthews et al. 2013).

Special Needs Diversionary Program. Based on the theory of therapeutic jurisprudence, the Special Needs Diversionary Program (SNDP) provides intensive supervision and treatment for juvenile probationers (ages 10–17) who display low levels of conduct and mental health disorders. The goal of the program is to rehabilitate the youths and prevent them from further involvement in the justice system. SNDP offers mental health services (including individual and group therapy), probation services (including life skills, mentoring, and anger management), and parental education and support. Specialized juvenile probation and professional mental health staff from the local mental health centers work together to coordinate intensive case-management services. The program follows procedures based on typical wraparound strategies. Services provided to juveniles include individual and family therapy, rehabilitation services, skills training, and chemical dependency.

In their study on SNDP, Cuellar and colleagues (2006) evaluated re-arrests for juveniles who participated in the program. They found that there were 63 fewer arrests per 100 youths served by the program over a 1-year period, compared with youths who had not been enrolled in the program.

For more information on these programs, click on the links below.

[Functional Family Therapy](#)

[Jefferson County Community Partnership \(Birmingham, Ala.\)](#)

[Multisystemic Therapy](#)

[Special Needs Diversionary Program](#)

Conclusion

The research presented shows that many youths with mental health issues in the justice system are in need of treatment. Substance use disorders are particularly prevalent. However, the intersection

between mental health and the juvenile justice system represents a challenging area for policymakers and practitioners, because the exact relationship between mental health issues and problem behaviors (such as delinquency) is not always clear (Schubert and Mulvey 2014). The research indicates there are shared risk factors for mental health issues and juvenile justice involvement; however, the research is less conclusive about whether mental health problems increase the odds of youth involvement in the justice system or whether being a part of the justice system increases youths' mental health problems.

Despite the prevalence of mental health disorders among justice-involved youths, particularly for those processed further into the system, many do not receive services to meet their needs (Teplin et al. 2013). In addition, there are discrepancies in referrals for treatment, particularly regarding race and gender (Teplin et al. 2003; Spinney et al. 2016).

However, there are several evidence-based programs that specifically target youths with mental health needs in the juvenile justice system and focus on reducing delinquency and other related problem behaviors by properly addressing both criminogenic risk factors and the mental health needs of these youths (Cuellar et al. 2006; Matthews et al. 2013).

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