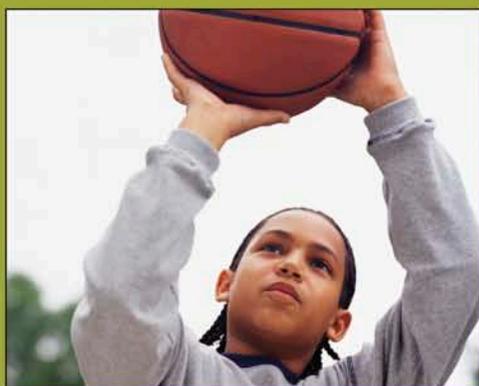


## Juvenile Justice Resource Series

# A Primer for Mental Health Practitioners Working With Youth Involved in the Juvenile Justice System





***A Primer for Mental Health Practitioners Working  
With Youth Involved in the Juvenile Justice System***

**Robert Kinscherff, Ph.D., Esq.**

National Center for Mental Health and Juvenile Justice  
Massachusetts School of Professional Psychology

**January 2012**



### **About the Technical Assistance Partnership for Child and Family Mental Health**

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) provides technical assistance to system of care communities that are currently funded to operate the Comprehensive Community Mental Health Services for Children and Their Families Program. The mission of the TA Partnership is "helping communities build systems of care to meet the mental health needs of children, youth, and families."

This technical assistance center operates under contract from the Federal Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The TA Partnership is a collaboration between two mission-driven organizations:

- The American Institutes for Research—committed to improving the lives of families and communities through the translation of research into best practice and policy, and
- The National Federation of Families for Children's Mental Health—dedicated to effective family leadership and advocacy to improve the quality of life of children with mental health needs and their families.

The TA Partnership includes family members and professionals with extensive practice experience employed by either the American Institutes for Research or the National Federation of Families for Children's Mental Health. Through this partnership, we model the family-professional relationships that are essential to our work. For more information on the TA Partnership, visit the Web site at <http://www.tapartnership.org>.

### **Suggested Citation:**

**Kinscherff, R. (2012). *A Primer for Mental Health Practitioners Working With Youth Involved in the Juvenile Justice System*. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health.**

## **Forward**

Each year, more than 2 million children, youth, and young adults formally come into contact with the juvenile justice system, while millions more are at risk of involvement with the system for myriad reasons (Puzzanchera, 2009; Puzzanchera & Kang, 2010). Of those children, youth, and young adults, a large number (65–70 percent) have at least one diagnosable mental health need, and 20–25 percent have serious emotional issues (Shufelt & Coccozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). System of care communities focusing on meeting the mental health and related needs of this population through comprehensive community-based services and supports have the opportunity to not only develop an understanding around the unique challenges this population presents, but also to decide how best to overcome those challenges through planned and thoughtful programs, strong interagency collaboration, and sustained funding.

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) recognizes the many challenges system of care communities face in working to better meet the needs of all of the children, youth, and young adults they serve. In an effort to help these communities meet the unique needs of young people involved or at risk of involvement with the juvenile justice system, the TA Partnership is releasing a resource series focused on this population. The TA Partnership has contracted with the National Center for Mental Health and Juvenile Justice (NCMHJJ) and other experts in the field to produce this resource series. Each brief examines a unique aspect of serving this population, from policy to practice, within system of care communities.

We hope that this resource series will support the planning and implementation of effective services, policies, and practices that improve outcomes for children, youth, and young adults involved or at risk of involvement with the juvenile justice system as well as their families.

## **A Primer for Mental Health Practitioners Working With Youth Involved in the Juvenile Justice System**

### ***Overview***

Many mental health practitioners were trained in programs or at a time when very little attention was paid during the course of training to youth involved in the juvenile justice system. For a variety of reasons, general clinical training does not ordinarily equip a mental health practitioner to operate within the juvenile justice context. Practitioners who have been trained within more recently developed programs with a “forensic” emphasis may be more familiar with adults within the criminal justice system than with juveniles, more focused upon technical assessments, such as competency to stand trial, than upon youth-specific developmental and functional assessments, or relatively unfamiliar with the emerging literature regarding youth with mental health needs who have had contact with the juvenile justice system or penetrated to its deeper end programs.

This paper provides an overview for mental health practitioners who provide professional services to youth who are involved with the juvenile justice system. This overview emphasizes emerging research and practices, the emerging conceptualization of trauma and its implications for youth involved with the juvenile justice system, and implications for policy and practice. While primarily intended for mental health professionals working within system of care communities or interested in developing a system of care collaboration in their area, this paper is relevant for any mental health practitioner providing professional services to youth involved or at risk of involvement in the juvenile justice system. It is also relevant for juvenile court and juvenile justice professionals whose work brings them into contact with youth with significant mental health needs.

### ***Youth with Mental Health Needs in Juvenile Justice***

It is well established that a high prevalence of youth who come into contact with the juvenile justice system have significant mental health needs. Each year more than two million youth and young adults come into direct contact with the juvenile justice system (Puzzanchera, 2009; Puzzanchera & Kang, 2010). Millions of others are at risk of system involvement for reasons varying from national policies, such as Zero Tolerance for misconduct in schools, to local differences in school, police, and prosecution practices across States and localities.

Research across different sites and time frames has consistently demonstrated that approximately 70 percent<sup>1</sup> of youth who come into formal contact with the juvenile justice system warrant at least one mental health diagnosis, and approximately 20 to 25 percent have serious emotional issues (Shufelt & Coccozza, 2006; Teplin, Abram, McClelland, Dulcan & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher & Santos, 2002). One influential study further determined that approximately 55 percent of males and females involved in the juvenile justice system warranted two or more co-occurring

mental health diagnoses, and that some 60 percent of youth who warranted a mental health diagnosis also met diagnostic criteria for a substance use disorder (Shufelt & Cocozza, 2006).

The high prevalence of youth with significant mental health needs and co-occurring substance use disorders is a disturbing counterpart to research findings about the elevated risk of criminal justice system involvement for adults with serious mental health needs, particularly if these adults also have substance abuse problems.<sup>2</sup> The gradual recognition over recent years of the high prevalence of youth with mental health needs in the juvenile justice system has led to disturbing findings about the system, a system that was not designed to identify and respond as a clinical service system to meet the needs of these youth. Juvenile justice programs and facilities often lack established policies and practices, sufficient clinical and staff resources, and/or adequate training to effectively meet the needs of these youth. Youth with significant mental health needs who do not pose heightened public safety risks may be nonetheless incarcerated.<sup>3</sup> Youth may be detained because mental health services are not available.<sup>4</sup> When detained or incarcerated in juvenile justice facilities, many youth will have poor or no mental health care.<sup>5</sup> Additionally, many secure juvenile facilities are characterized by poor training for staff, inadequate clinical services, and improper medication practices.<sup>6</sup>

The need has become increasingly clear for:

- mindful public policy decision-making regarding youth with mental health needs and the processes by which they penetrate the juvenile justice system
- adequate training on adolescent development and mental health for professionals at all points in the juvenile justice system from “direct contact” professionals (e.g., police, judges, probation officers, juvenile facility staff) to senior administrators of court and juvenile justice systems
- training on evidence-based practices (EBP) and clinical characteristics for court-involved youth for community-based social services and clinical services providers
- thoughtful consideration of whether both public safety objectives and the mental health needs of many of these youth could be better met through diversion from unwarranted penetration into the juvenile justice system

Familiar practices within traditional roles and organizational silos have failed to prevent the penetration of youth with significant mental health needs into the juvenile justice system. Development and implementation of research-informed policies and effective practices call for innovative collaborative partnerships reflecting and balancing the perspectives, roles, and goals of juvenile justice professionals, defense counsel and prosecutors, judges, probation staff, mental health and substance abuse professionals, educational and special educational professionals, and families and the youth themselves.

Effective collaborative partnerships ranging from “systems” discussions of broad public policies to local partnerships specifically tailored to local needs and conditions are

essential to achieving both public safety objectives and meeting the mental health needs of youth in the juvenile justice system. Whatever other perspectives or interests they may have, potential partners and stakeholders can ordinarily agree upon achieving common goals of (a) community, family, and youth safety, (b) supporting the positive development and success of youth involved in juvenile court, (c) positive engagement of family and community for youth at risk, and (d) cost-effective use of resources and professional expertise to meet needs, reduce risk, and support positive development over time. These collaborative partnerships can choose to identify and address systems gaps and service needs at any of several critical intervention points<sup>7</sup> from initial contact with the juvenile justice system and referral through the return of youth following periods of out-of-home juvenile justice placement.<sup>8</sup> In particular, community-based partnerships can build upon the experience of models such as systems of care<sup>9</sup> to yield improved outcomes for youth with mental health needs while avoiding unwarranted out-of-home or institutional placements.

### ***Strangers in A Strange Land: Mental Health Clinicians and Juvenile Justice***

Challenges for mental health professionals providing services to youth involved with the juvenile justice system include:

- appreciating the distinction between “rehabilitation” and “treatment” and how that distinction shapes assessment and treatment formulation and clinical practice
- effectively applying the lens of developmental psychology to youth with histories of delinquent misconduct
- providing reliable diagnosis and case formulation for youth who commonly present with complex clinical pictures, histories that may not be well-understood, and backgrounds requiring cultural competence skills on the part of the clinician
- discerning and articulating the links between a youth’s clinical picture and the misconduct that is of concern to juvenile justice
- Identifying and implementing evidence-based interventions
- incorporating into clinical formulation and interventions the emerging research regarding the developmental impact of trauma, adolescent brain development, and adverse childhood experiences

#### **Distinguishing Rehabilitation from Treatment**

“Rehabilitation” and “treatment” are sometimes used interchangeably regarding youth with juvenile justice involvement. This is potentially misleading since the concept of “rehabilitation” is broader than that of clinical “treatment.” Psychotherapeutic treatments, psychiatric medications, and other clinical interventions may be elements in the rehabilitation of a juvenile with mental health needs, but “rehabilitation” is a broader concept that encompasses all domains relevant to supporting a youth’s ability to live in the community without criminal misconduct. These domains commonly include educational, vocational, recreational, social, and other needs associated with the goal of rehabilitation: reducing risk of delinquent recidivism. Mental health practitioners

providing assessments regarding the rehabilitation of juveniles should be attentive to the implications of distinguishing between rehabilitation and clinical treatment of mental health disorders (Kinscherff, 2006),<sup>10</sup> including:

- Assessments of youth involved with the juvenile justice system are most relevant when they address rehabilitation. The recommended services or interventions must specifically link to case-specific factors giving rise to delinquency and to factors that would reduce recidivism risk.
- The recommended services or interventions must actually be available, since rehabilitation cannot occur if the needed services cannot be accessed. The law in some jurisdictions further requires that services or interventions must be accessible through the juvenile justice system. Where the optimal services cannot be accessed, the clinician still articulates what the optimal services would be and why, but also provides an analysis of whether, or to what extent, accessible services are likely to have an impact upon rehabilitation as well as symptoms of mental health disorders.
- While solid clinical skills are essential, mental health practitioners must also be familiar with research regarding developmental trajectories of delinquent misconduct, and the psychiatric and/or cognitive impairments commonly found among delinquent populations.
- Mental health practitioners must also be familiar with and apply research regarding the efficacy of clinical assessments and interventions specifically relevant to reducing recidivism risk (rehabilitation) as well as symptoms and functional impairment arising from mental health disorders (treatment).
- In addition to the dimensions of mental health practice described above, clinicians must also be familiar with relevant law, policies, and practices of the specific juvenile justice system in which they are providing services, and the resources accessible through that system.

### **The Lens of Developmental Psychology**

The lens of developmental psychology calls for assessing a youth across multiple developmental domains (e.g., emotional, cognitive, interpersonal, moral, physical) to generate an individualized understanding of the origins, meaning, and maintenance of their behavior. For youth involved with the justice system, this means that similar concerning behaviors may be a common endpoint arising from very different developmental trajectories. For example, the fact that youth in a group engage in a common delinquent behavior (e.g., assault, robbery, sexual offense, fire setting) does not mean that they also must share any other important characteristics. They may have very different life histories, learning capacities, risk and protective factors, mental health needs, talents or ambitions although they shared a common behavior at some point. Misconduct among youth may have very different patterns of onset or frequency, be maintained by different factors and may reflect different kinds of difficulties. For example, assaultive behavior in one adolescent may reflect an intensely emotionally reactive response to perceived threat, but for another it may reflect a deliberate and focused effort to intimidate, project power, or achieve goals. Sexual misconduct in one

adolescent may reflect misguided efforts to achieve emotional intimacy while in another it may reflect calculated efforts to dominate or even humiliate the victim.

Failure to view a youth and that youth's misconduct through the broad lens of individualized developmental psychology may result in poor matching or even mismatching of interventions. For example, a youth with a history of assault may be placed in an anger management group that presumes the youth is "losing control" of his temper or he has difficulties detecting options to violence. However, it may be instead that his threatened and actual assaults are deliberately chosen strategies to achieve instrumental goals such as social status or accessing resources (e.g., robbery to get money). Another youth with a history of assault but also significant trauma may be placed in a juvenile justice facility with a highly correctional model that fails to appreciate that his assaults occur at times when he becomes overwhelmed by an immediate sense of threat; his "meltdowns" and assaults are then met with increasingly severe sanctions that actually increase his sense of threat and lack of safety and thereby increase his incidents of assault.

Individual characteristics of the youth must also be taken into consideration when matching the youth with interventions. For example, a juvenile sexual offender treatment group is unlikely to be very helpful for a youth with a severe verbal learning disability that compromises his ability to take in information when it is presented orally. A youth who is functionally illiterate will not do well with interventions that rely upon journaling or written assignments. A youth with an attention disorder or hypervigilance arising from trauma is unlikely to benefit from interventions that occur in crowded, loud, or chaotic environments. The individual characteristics of youth must also be taken into account when identifying potential strengths or protective factors, identifying specific attitudes or behaviors relevant to understanding them and their risks/needs, and selecting strategies to suppress or replace delinquent attitudes or misconduct.

### **Diagnosis in Juvenile Justice: Challenges and Links to Misconduct**

Diagnosis is useful for categorizing and communicating various symptoms or difficulties, and accurate diagnosis may be a critical element for putting together a broader understanding of a specific youth. Diagnosis may also suggest particular interventions known or believed to be helpful for addressing the criteria that comprise the diagnosis. But diagnoses are always "working hypotheses" that are subject to review and change on the basis of new information, a reformulation of the information already available, or even changes in the criteria comprising the diagnosis itself. Accurate diagnosis is useful, but it cannot be solely relied upon in addressing the mental health needs of youth in the juvenile justice system.

One complication is that diagnosis in childhood and adolescence is tricky under the best of circumstances. Youth are constantly in the process of developing and are a "moving target" for professionals attempting to diagnose them. Expressions of symptoms of mental disorder may differ across childhood and adolescence, or adolescence and adulthood. For example, the self-preoccupation or the heightened energy level that is normal among adolescents may represent a diagnosable condition if still present in a

forty-year old adult. Diagnosis is especially challenging when youth, such as those in juvenile justice settings, have complicated or difficult life histories and complex clinical presentations. The reliability of clinical diagnosis may be deeply compromised without accurate or sufficiently detailed information regarding the history and functioning of the youth over time, or the emergence of the misconduct leading to juvenile justice involvement.

A second complication is that many symptoms of mental disorders in youth are “non-specific,” meaning that they may be found in a variety of different disorders among a broader cluster of symptoms that comprise a particular disorder. For example, irritability can be a symptom of Major Depressive Disorder, Bipolar Disorder, or Post-Traumatic Stress Disorder (PTSD). Functionally significant impairments in attention and concentration may be found in Attention Deficit Disorder (with or without Hyperactivity), PTSD, Major Depressive Episode, Bipolar Disorder, or persisting effects of concussion after a blow to the head.

The presence of “non-specific” diagnostic criteria, shifting developmental manifestations of mental disorder, and potential overlap of two or more co-occurring disorders create challenges for reliable diagnosis. Mental health practitioners providing diagnostic assessments of youth involved in the juvenile justice system are advised to rely upon empirically validated structured diagnostic tools to improve identification and reduce diagnostic error and bias.

It is also important to clearly articulate what specific impairments arise from the diagnosed condition(s) and how severely the youth’s daily functioning is compromised by those impairments. Diagnosis of a youth is not the same as a sufficiently detailed individual functional description of that youth across multiple developmental dimensions (e.g., cognitive, emotional, moral, social) currently or over time. Nor is diagnosis ordinarily sufficient by itself to permit effective case planning, case management, or optimal matching with interventions.

A third complication is that diagnosis is rarely sufficient to communicate what, if any, specific link there is between a diagnosed mental disorder and the conduct that brings the youth into contact with the juvenile justice system. In fact, the Diagnostic and Statistical Manual of Mental Disorders IV-Text Revisions (DSM-IV-TR)<sup>11</sup> specifically cautions against drawing forensic conclusions based solely upon diagnosis. Recalling that the overarching goal of the juvenile justice system is rehabilitation to reduce recidivism risks, it is important to articulate in each individual case the relationship between a diagnosed condition, its contribution to the misconduct, and the manner in which treatment might or might not contribute to lowering risk of recidivism.

For example, one adolescent with a diagnosis of depression may manifest that depression by marked irritability that significantly contributes to his assaulting others. But as his depression is treated successfully, the likelihood of an assault also substantially lessens. If this adolescent does not have a significant history of physical aggression when not clinically depressed with marked irritability, it is likely that

effective treatment of his depression alone would substantially lower his risk of assaulting others. Here, mental health treatment alone is sufficient to meet the goal of rehabilitation.

Another adolescent with a diagnosis of depression may manifest that depression primarily by withdrawal and social isolation, sleeping for many hours a day, and feeling a pronounced lack of physical energy. If this adolescent also has a prior history when not depressed of assaulting others to achieve intimidation or robbery, effective treatment of his depression may actually increase the likelihood of him returning to his baseline of assaulting others as he feels better and his physical energy returns. Here, effective treatment of his depression alone would be insufficient to meet the goal of rehabilitation, and he would require further assessment and intervention to meet the goal of rehabilitation.

### ***Common Diagnoses Among Youth in the Juvenile Justice System***

Psychiatric diagnoses among youth involved with the juvenile justice system, though often unrecognized,<sup>12</sup> are wide ranging.<sup>13</sup> As outlined in a National Center for Mental Health and Juvenile Justice (NCMHJJ) study (2006), the diagnostic categories below are relatively common among males and females in the juvenile justice system (Shufelt & Coccozza).<sup>14</sup>

#### **Anxiety Disorders**

Anxiety disorders are diagnosed in approximately one quarter of males (26.4%) and just over half of females (56.0%) involved with the juvenile justice system. The hallmark of anxiety disorders is clinically significant impairment of functioning arising from physical (e.g., increased heart rate, elevated blood pressure, increased respiration, restlessness) and psychological (e.g., unwanted intrusive memories, fearfulness, problems with attention and concentration, heightened reactions and irritability) symptoms. Anxiety disorders include Generalized Anxiety Disorder (a person's functioning is compromised by a persistently heightened state of anxiety), Acute Stress Disorder (a person's functioning is compromised by extreme nervousness and reaction following a highly stressful event), and PTSD (a person's functioning is persistently compromised by symptoms related to exposure to one or more life-threatening or other extremely stressful events). Girls are perhaps more likely to present with a stress-related anxiety disorder due to their greater likelihood of experiences of direct victimization, but as is discussed below, boys involved with the justice system also reflect a high rate of trauma exposure. Anxiety disorders arising from trauma exposures are discussed in greater detail below.

#### **Mood Disorders**

Among youth in the system, mood disorders are diagnosed in approximately 1 in 7 (14.3%) males and just less than 1 in 3 (29.2%) females. The hallmark of mood disorders is a clinically significant impairment of functioning arising from profound disturbances of mood beyond what would be developmentally expectable in adolescence. Mood

disorders commonly found among youth in the juvenile justice system include Major Depressive Disorders (single episode or recurrent) and Bipolar Disorder.

Youth with Major Depression manifest observable symptoms (e.g., withdrawal, tearfulness, disturbance of sleep or appetite) and subjective symptoms (e.g., hopelessness and demoralization, poor self-esteem, unreasonable guilt or self-recrimination, sadness and/or irritability). Sometimes youth suffering from depression consider or engage in self-harming behavior including suicide. They may also behave in ways likely to result in negative consequences to themselves because they no longer care about negative consequences or unreasonably believe that they deserve them.

Depressed youth in juvenile justice settings may attract attention due to their marked irritability, apparent demoralization and hopelessness, or efforts to withdraw. If unrecognized as arising from depression, markedly irritable youth are often viewed as “having attitude,” warranting a disciplinary response, and demoralized, hopeless, or withdrawn youth are viewed as “not caring about consequences” or “unwilling to go with the program.”

Bipolar Disorder is a major mental illness that typically emerges in adolescence or young adulthood and is characterized in its manic phase by symptoms clustering around extreme mood turbulence (e.g., bursts of heightened activity, marked irritability, racing thoughts that are difficult to redirect, pressured speech that is difficult to interrupt, highly impulsive and poorly-considered behavior, diminished appetite and sleep) that may or may not alternate with a more clearly depressed mood. Sharp increases in this diagnosis among youth in recent years has led to calls for reliability studies of the diagnosis<sup>15</sup> and attention has been focused upon diagnostic complexities given its overlap with Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, histories of trauma and adversity, and histories of aggression.<sup>16</sup>

In juvenile justice settings, youth with Bipolar Disorder may demonstrate difficulty responding to structure and expectations, particularly when the disorder is manifested by extreme impulsivity, emotional reactivity, irritability, and hyperactivity. When at its extreme, Bipolar Disorder results in youth who are often clearly acutely mentally ill. But when Bipolar Disorder is less severely expressed (“hypomanic”), these youth are often viewed in juvenile justice settings as provocative and defiant in ways that provoke disciplinary responses.

### **Attention Deficit and Disruptive Behavior Disorders**

Disruptive behavior disorders were diagnosed in approximately 45 percent of males and just over half (51.3%) of females involved with the juvenile justice system.

Attention Deficit Hyperactivity Disorder (ADHD) is a developmental disorder characterized by problems with attention and concentration, and which commonly presents along with impulsivity, restlessness, and hyperactivity.<sup>17</sup> ADHD affects about 3-5 percent of children<sup>18</sup> and is diagnosed about twice as frequently among boys than girls. There are three subtypes of ADHD. A youth with ADHD may present primarily with

problems associated with significant impulsivity, restlessness, and hyperactivity and so would be classified as the predominantly “hyperactive-impulsive” subtype. Another youth with ADHD may present primarily with problems with attention and concentration and lack prominent hyperactivity or impulsivity, thus classified as having the “predominantly inattentive” subtype. Most youth with ADHD have problems associated both with impulsive/hyperactive behaviors and significant impairments in attention/concentration, so are classified as the “combined” subtype.

ADHD can compromise academic and social learning, age-appropriate decision-making, and ability to conform to behavioral expectations in school and other settings. While most youth with ADHD do not go on to develop Disruptive Behavior Disorders, developmental complications associated with ADHD (e.g., learning difficulties, poorer peer relationships) are risk factors for developing these disorders through childhood and into adolescence.

Youth with unrecognized or untreated ADHD in juvenile justice settings may be viewed as “not listening” due to inattention, “pushing the limits” due to impulsivity and poor decision-making, or “disruptive” due to their hyperactivity and ability to annoy peers and staff. This is particularly the case if the youth has a moderate to severe manifestation of ADHD.

Disruptive Behavior Disorders include Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). ODD is largely characterized by tantrums, intrusive, disruptive, and annoying behaviors. The more serious CD is characterized by: (a) conduct constituting serious violations of household or school rules (and may be reflected in status offenses such as truancy, stubbornness, running away); (b) physically and/or sexually aggressive behavior that can or does harm other persons or animals; (c) conduct deliberately resulting in property loss or damage; and, (d) lying, deceitfulness, stealing, or theft without confrontation of the victim.

The diagnostic criteria for CD describe behavior that could result in court involvement as status offenses but primarily as delinquent offenses against persons and/or property. Since the diagnosis itself requires that at least three of the conduct disordered behaviors must be present for at least six months, it tends to reflect versatile and multiple misconduct that are a broader pattern of misconduct. Additional features include limited capacities for empathy or for experiencing genuine remorse for misconduct.

Like the other diagnoses described in this brief, CD can present from mild forms of expression (fewer criterion met, minimal harm to persons) to severe forms (many more criteria met than required for diagnosis, substantial harm to persons, and damage/loss to property). Careful differential diagnosis is required to identify other conditions that are commonly co-occurring in CD such as Mood Disorders, ADHD, PTSD and Substance Use Disorders. Without careful assessment, these co-occurring disorders may not be recognized among youth who present with CD.

Onset of problem behaviors in early childhood, history of parental abuse, poor supervision, financial hardship, increased number and severity of diagnostic criteria,

and co-occurring substance use and/or ADHD are associated with poor outcomes<sup>19</sup> and the need for more intensive, multi-modal interventions. Youth with childhood onset of Conduct Disorder (under age 10) comprise a higher-risk cohort of youth who are less likely to desist from criminal misconduct as they get older than are those whose Conduct Disorder is of adolescent onset whose misconduct tends to sharply diminish as they enter young adulthood.

Given that ODD describes behavior that is likely to result in significant friction with adults and peers, and that CD describes many delinquent behaviors likely to prompt juvenile justice responses, it is puzzling that less than half of males and just over half of females in the NCMHJJ sample were included in the ADHD and Disruptive Disorders group. This means that roughly half of males and females in the juvenile justice system lack diagnoses that would specifically constitute disruptive, defiant, or delinquent behaviors highly likely to prompt a police and then juvenile justice response.

Youth with ODD and CD in juvenile justice settings pose significant challenges when they also present with other diagnosable disorders. On the one hand, especially youth diagnosed with CD may be seen too quickly as delinquent youth on a trajectory towards adult criminality and other diagnoses missed. If those co-occurring disorders are not identified and effectively treated, the youth may be less likely to respond to interventions or to make use of protective factors that can contribute to desisting unlawful behavior. On the other hand, if other mental health diagnoses are awarded then the youth's misconduct may be too quickly attributed to those mental disorders and the misconduct seen as "acting out" mental health issues rather than reflecting the thinking errors, attitudes, and beliefs that maintain delinquent behaviors. This is where the lens of developmental psychology described earlier in this paper and reliable differential diagnosis are particularly important in identifying, assessing, and responding on an individual basis to recidivism risks, protective factors, and mental health and other needs.

### **Substance Use Disorders**

Approximately 43 percent of males and 55 percent of females involved in the juvenile justice system had substance use disorders. Substance abuse disorders reflect use of alcohol or other controlled substance in a manner that clinically impairs one or more domain of functioning (e.g., academic, social, legal). Substance dependence disorders not only reflect use that is clinically impairing in one or more domains of functioning, but represent development of physical and/or psychological dependence. The prevalence of substance use disorders indicates that many youth involved in the juvenile justice system present with a substance use disorder and one or more co-occurring mental health disorders. This suggests that screening and assessments should focus upon identifying co-occurring substance use and mental health disorders and that intervention should simultaneously target substance use and mental health concerns rather than assigning them to poorly coordinated "silos" of clinical care.

In addition to current substance use disorders among juveniles, mental health professionals should consider the possibility of parental substance abuse. Specifically,

differential diagnosis should consider Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effect (FAE) and their related cognitive, affective regulation, and interpersonal deficits given the disproportionate rates of fetal alcohol exposure during pregnancy among delinquent youth.

### ***Trauma: The Chimera or “Shape Shifter” Within Juvenile Justice?***

In Greek mythology, the Chimera was a beast with a lion’s head, a goat’s body, and the tail of a serpent. Those who saw only part of the beast would mistake it for a lion, a goat, or a serpent without recognizing that they were seeing only a part of the total beast. For those with more modern science fiction interests, one might think of the “shape shifter” from the Star Trek series, a creature capable of adopting virtually any physical form.

Trauma may well be the Chimera or “shape shifter” of developmental psychopathology (the emergence of mental disorders across time) and diagnosis for youth within the juvenile justice system. Emerging research from several fields increasingly suggests that: (a) youth involved with the juvenile justice system have very high rates of acute and chronic trauma exposures; (b) that the impact of trauma and of a youth’s efforts to adapt to those impacts can manifest very differently over the course of development and across different domains (cognitive, emotional, social, behavioral, physical); and, (c) that the existing framework for diagnostically recognizing post-traumatic adaptations is not well-suited to how youth actually present clinically.

Trauma is the result of a highly stressful experience(s) that overwhelm an individual’s ability to cope. Sometimes traumatized persons are able to recover, benefit from support, and move on without significant or persisting functional impairment. Other persons may be overwhelmed by intense single episode events (e.g., witnessing a parent being murdered, being sexually assaulted) or cumulatively by traumatic events (e.g., witnessing multiple episodes of community or domestic violence, being sexually abused over a period of time). How trauma manifests is highly individual in terms of its immediate impact or efforts of the victim to adapt to the impact of the traumatic events. In children and adolescents, trauma-related symptoms or their efforts to adapt to the traumatic experience or persisting trauma-related symptoms can change their manifestation as the traumatized child continues to age and to develop.

Traumatic symptoms and post-traumatic adaptations can also be diagnostically confusing in children and adolescents, particularly if they may resemble the “non-specific” criteria for psychiatric diagnoses. For example, without careful consideration of a trauma history, the hypervigilance of a traumatized youth may be mistaken for the problems with attention and concentration of ADHD. The emotional numbing that emerges as a defense against overwhelmingly painful trauma-related emotions may be confused with depression, and, particularly in delinquent youth with serious crimes against persons, may be misunderstood as a lack of capacity for empathy for others or lack of remorse for misconduct.<sup>20</sup> The intensely reactive emotional dysregulation that can result from trauma may be mistaken for the emotional instability of an emerging

Bipolar Disorder, particularly when a significant trauma history is unknown or inadequately considered by the diagnosing clinician.

Traumatic symptoms and post-traumatic adaptations may also present developmentally “moving targets” in the same youth over time. For example, a youth who presented with prominent anxiety and clearly trauma-related symptoms (e.g., intrusive thoughts of the traumatic event, traumatic nightmares) just after the trauma exposure may present later primarily with the adaptations to the acute impact of the trauma, such as psychological numbing to dampen anxiety, avoidance of situations or persons that may trigger reminiscences of the trauma, and intense emotional dysregulation when efforts to control emotions fail or trauma responses are triggered again.

To avoid being tricked by “Chimera” of psychological trauma, screening in juvenile justice settings should include screening for traumatic exposure and common trauma-related symptoms. Clinicians working with delinquent populations must carefully consider trauma in developmental formulation, differential diagnosis, and functional assessment. Failure to do so risks serious errors in identifying mental health needs related to trauma exposures, clinical diagnosis, case formulation, and matching youth with clinical interventions.

### **Prevalence of Trauma in Juvenile Justice**

There is a growing body of research demonstrating that a significant number of youth with trauma histories come into contact with the juvenile justice system.<sup>21, 22</sup> One study (Abram, Teplin, et al., 2004) found that 92.5 percent of youth in an urban juvenile detention center had experienced at least one traumatic event (mean: 14.6, median: 6) with 11.2 percent meeting criteria for PTSD in the previous year.<sup>23</sup> More broadly, a National Child Traumatic Stress Network (NCTSN) study (2008)<sup>24</sup> determined that more than 50 percent of youth in the juvenile justice system have had trauma exposures and that over 50 percent of them had developed at least some trauma symptoms.

This should not be surprising given that many youth who come into contact with and then penetrate deeply into the juvenile justice system have known severe emotional disturbances and histories of multiple system involvement. One study (Meusner & Taub, 2008)<sup>25</sup> of male and female youth with these characteristics found that 28 percent met criteria for PTSD (girls: 42%, boys: 19%) and that those with PTSD were also more likely to have histories of running away, delinquent behavior, self-injury, anxiety and depression, and poorer functioning at school and at home. This study found that “PTSD is a common but under-diagnosed disorder among adolescents with severe emotional and behavioral disorders involved with multiple service systems” and recommended routine screening for PTSD among adolescents receiving mental health services.

### **Diagnostic Challenges Arising From Trauma Histories**

The complexities of psychological trauma as the “Chimera” of diagnosis and case conceptualization has been reflected in the controversy in recent years regarding how to best conceptualize and describe the developmental impact of trauma. It is now apparent that there are important clinical differences between children and adults who are

exposed to a single traumatic episode and those exposed to chronic or multiple trauma exposures. While the diagnosis of PTSD captured one variant of response to traumatic stress, it is arguably inadequate to adequately describe persons with traumatic stress histories that were more extensive and/or began in childhood rather than adulthood.

The existing diagnostic categories related to trauma among children and adolescents are a grey area of diagnosis insufficient to capture either the acute or the enduring developmental impact of psychological trauma. As a result, mental health professionals may fail to recognize symptoms or functional deficits that are actually related to trauma exposures. For example, mood instability arising from trauma may instead be diagnosed as Bipolar Disorder, trauma-related difficulties with attention/concentration may be diagnosed as ADHD, and flat emotional states may be diagnosed as depression rather than the “emotional numbing” arising from trauma. A diagnosis of “Developmental Trauma Disorder” has been developed intended to “capture the reality of the clinical presentations exposed to chronic interpersonal trauma.”<sup>26</sup> While not currently in the Diagnostic and Statistical Manual of Mental Disorders (DSM) system,<sup>27</sup> its proponents argue that youth are “ill-served by the current diagnostic system as it frequently leads to no diagnosis, multiple unrelated diagnoses, an emphasis on behavioral control without recognition of interpersonal trauma in the etiology of symptoms, and a lack of attention to ameliorating the developmental disruptions underlying symptoms.”<sup>28</sup>

As applied to youth in juvenile justice settings, those who do not meet the full criteria for PTSD may not receive a diagnosis that reflects the trauma origins of many of the features with which they present clinically. They may receive multiple diagnoses that individually capture some portion of their clinical presentation but which are not integrated in the clinical developmental formulation of the youth as having a common origin in trauma exposures. Particularly when youth present with defiant, provocative, aggressive or illegal behaviors, failure to recognize the contributions of trauma exposures to those behaviors may result in an unsophisticated focus upon behavioral control that may actually make the concerning behaviors worse.

### **Intervention Challenges Arising From Trauma Histories**

Finally, without recognizing the contribution of trauma exposures to the onset of symptoms and the emergence or maintenance of misconduct, interventions may fail to address critical developmental disruptions. These can include problems with attachment, compromised ability for reciprocal relationships, profound emotional dysregulation, impaired empathy for others and/or self, risk-taking and sensation-seeking, aggression to self and/or others, extreme mistrust, demoralization, sense of fundamental damage and persistent danger, poor capacities for self-soothing, and somatic complaints.<sup>29</sup> These are also the clinical characteristics of youth at risk for increasing penetration into the juvenile justice system if these trauma-related mental health needs are not identified, assessed, and targeted for effective interventions.

As of this writing, the proposed diagnosis of Developmental Trauma Disorder may or may not be included in the upcoming DSM-V nosology for psychiatric diagnosis.

Whether or not Developmental Trauma Disorder is included in the DSM-V, it is essential that mental health professionals incorporate into practice diagnosis and intervention-planning consistent with the research<sup>30</sup> upon which the proposed diagnosis is based. Mental health professionals must consider the likelihood that existing diagnostic classifications of trauma-related disorders or developmental distortions remain inadequate for diagnosis,<sup>31</sup> describing functional impacts of trauma, and for supporting adequately trauma-sensitive developmental case formulations and interventions. Sophisticated diagnostic and clinical assessment and case formulations must include both acute and developmental features of the impact of trauma upon youth. This is particularly the case when youth are at increased risk of continued involvement in the juvenile justice system by virtue of their post-traumatic adaptations e.g., emotional and behavioral dysregulation, extreme thrill-seeking or risk taking behavior, extreme and persistent mistrust).<sup>32</sup>

Emerging research also indicates the importance of considering the impact of stress and trauma on brain development<sup>33</sup> contribution of adverse childhood experiences to early and persisting adoption of risk behaviors (Anda, Felitti, et al, 2006),<sup>34</sup> and the interaction among Conduct Disorder, high-risk behaviors, life-style factors, and PTSD (Karestan, Koenen, et al, 2005; Newman, 2002).<sup>35</sup> More recent research describes how chronic or multiple traumatic exposure alters brain development in a way that leads youth towards misperceptions of threat, mistrust, emotional reactivity and dysregulation, extremely short-term perspectives, risk-taking, and efforts to block negative emotions by behaviors such as substance abuse or high-intensity behaviors.<sup>36</sup>

Mental health practitioners must take into account the developmental impact of trauma exposures when applying the lens of developmental psychopathology in clinically formulating each case, and in articulating what may not be readily captured in the existing diagnostic framework. Traumatic exposure alone does not necessarily cause all of their problems but the origins of some persisting behavioral, emotional, and other difficulties can be traced to trauma. Additionally, and as importantly “traumatic stress can interfere with a child’s ability to think and learn, and can disrupt the course of healthy physical, emotional, and intellectual development.”<sup>37</sup> When identified, youth demonstrating developmental and/or functional impact related to trauma exposures should be referred to empirically-based interventions effective with juvenile justice populations.<sup>38</sup>

### ***Implications for Future Policy and Practice***

The high prevalence of youth with significant mental health and/or substance use disorders who are involved in the juvenile justice system is a call for action and reconsideration of familiar policies and practices. Juvenile justice has an essential role to play in the rehabilitation of juveniles who pose real safety risks to their communities or whose developmental trajectories appear to be leading them into continued criminal misconduct in adulthood. It is crucial that this core mission of juvenile justice not be compromised.

At its heart, juvenile justice is a form of “future victim prevention” intended to secure safety for individuals and communities by intervening with youth whose misconduct has already compromised the rights and interests of others. It is crucial that the core mission not be compromised by devoting limited juvenile justice resources to youth who can be responsibly diverted at a variety of points from unwarranted penetration deeper into the juvenile justice system. This is particularly the case for youth who can be supported in positive development through community-based responses or whose significant mental health needs outstrip the capacities of juvenile justice to meet those needs. Additionally, asking the juvenile justice system to become the default mental health services system for youth who do not pose significant public safety risks or who are likely to respond to community-based mental health services may contribute to a loss of focus upon the core mission of juvenile justice.

Despite other important differences among mental health professionals regarding policy and practice, or differences in perspective arising from their various roles in juvenile courts and juvenile justice, most can probably agree that it is best to avoid unnecessary penetration of youth into the juvenile justice system, ineffective use of scarce fiscal and human resources, and loss of focus upon the core mission of juvenile justice. Mental health professionals have an important role to play in collaborations with other professionals in youth-serving systems (e.g., court, juvenile justice, child welfare, education, mental health), youth, and families in avoiding this unwanted outcome while crafting effective alternatives that meet the needs of youth while supporting the core mission of juvenile justice.

Effective juvenile justice responses will increasingly need to be informed by sources as diverse as developmental neurobiology, the epidemiology and impact of adverse childhood experiences, the developmental impact of traumatic stress in childhood and adolescence, the effectiveness of community-based responses to youth at risk, and the emergence of empirically-based methods of screening, assessment, and intervention with youth.

These responses in juvenile justice policy and practice will need to be informed by the following:

- Given the prevalence of youth with significant mental health needs in the juvenile justice system (and particularly as they penetrate into deeper-end services), it is critical to develop research-informed policies and practices to avoid rendering the juvenile justice system into a tacit forensic mental health management system for youth with mental disorders who have committed delinquent offenses. It is not a proper use of the juvenile justice system to let it become the fall-back system due to obstacles in accessing effective community-based mental health care. Since youth with significant mental health needs who are at risk of juvenile justice involvement tend to be the same youth who come into contact with other systems (e.g., special education, child welfare, health and mental health care), increased priority must be given to community-based collaborative initiatives that cross “systems,” agencies and providers.

- Similarly, capacities for screening and assessment must be developed at each potential point of contact a youth has with the juvenile justice system, from initial intake following arrest through community reentry following a period of detention or incarceration. Screening and assessment capacities must rely upon standardized, research-based screening tools and assessment procedures that are specifically attuned to the clinical assessment needs of the youth, informed by practices specific for the assessment of youth with histories of delinquent misconduct, and relevant to the needs of the juvenile justice system. These screening and assessment capacities must be linked with community-based collaborative services and designed to facilitate diversion from further penetration into the juvenile justice system when doing so is consistent with public safety and support of positive youth development.
- Whether the youth is in the community under supervision or has penetrated into juvenile justice institutions, screening and assessment will be most effective when it results in access to evidence-based and empirically validated interventions that are specifically matched to the clinical needs of the youth, including those features of a youth's mental health needs that are linked to recidivism risk or protective factors.
- The high co-occurrence of substance use disorders and mental health disorders in youth involved in the juvenile justice system indicates that youth with these co-occurring conditions need access to interventions capable of meeting both of these treatment needs. Treatment services that decline to treat a youth for mental health disorders until they are no longer abusing substances, or decline to treat a youth for substance abuse until they have been treated for mental health disorders, are a poor match for these youth.
- The high prevalence of youth with juvenile justice involvement who meet existing criteria for Anxiety Disorders (including PTSD) and who otherwise have histories of chronic and/or multiple traumatic exposures indicates that the juvenile justice system specifically requires a well-developed trauma-informed approach to screening, assessment and intervention. The tools and methods relied upon for screening and assessment must include screening for trauma histories and potential manifestations of traumatic exposure. Assessments of trauma conducted by mental health professionals should extend beyond current diagnostic categories such as PTSD to consider the dimensions suggested by Developmental Trauma Disorder as part of an integrated assessment of a youth's history and functioning. This would be particularly important in a clinical formulation of the links between a youth's trauma history and high-risk behaviors and delinquent misconduct, or identification of complications to rehabilitation that may arise from the trauma history.

Juvenile justice administrators may want to consider working in collaboration with public health administrators to routinely collect information regarding adverse childhood experiences at points of contact for each youth. This would permit further policy and practice development based upon the compelling research available through the Centers for Disease Control<sup>39</sup> regarding the association of specific adverse childhood experiences, adoption of health and social risk behaviors in adolescence and young adulthood, and poorer social and health outcomes in adulthood. Specifically, correlations have been found between the number of adverse

childhood experiences and adolescent onset of antisocial behavior, drug use, and depression.<sup>40</sup>

- Development of a trauma-informed approach to juvenile justice that recognizes the contribution of trauma to the emergence of high-risk behavior and delinquent misconduct, but which forges an alternative between the two traditional juvenile justice models of punishment or mental health intervention. Griffin, Germain and Wilkerson (in press, 2011)<sup>41</sup> thoughtfully describe a trauma-informed approach which places this alternative within current jurisprudence such as the US Supreme Court decisions of Roper and Graham, and which finds middle ground between punitive approaches and mental health approaches.

The trauma-informed approach does not hold the youth responsible for the traumatic experiences but holds the youth accountable for learning how to manage perceptions, emotional reactions and behaviors when an acute trauma response is triggered or when maladaptive attitudes, beliefs, and behaviors emerge in response to trauma. It takes a strengths-based rather than a punitive approach, teaches specific alternative skills as the youth is held accountable for how they choose to manage their trauma-based perceptions and reactions, and “relies more on the use of supportive adult relationships in recovery.”<sup>42</sup> Mental health professionals with the requisite clinical skills and juvenile justice experience have an important role to play in collaboratively conceptualizing and implementing trauma-informed approaches at all levels of the juvenile justice system.

- Mental health professionals providing services to youth involved in the juvenile justice system must recognize that standard clinical training does not adequately equip them to work with delinquent youth, and they must develop specialized skills for clinical assessment, risk and needs assessment, and implementation of evidence-based interventions. Mental health systems should seek opportunities to collaborate with colleagues in juvenile court and juvenile justice settings to create training opportunities, particularly for master’s and doctoral clinical professionals, nurses intending to work with mental health populations, and physicians in clinical and forensic psychiatry residency programs.

## **Summary**

The juvenile justice system currently has contact at multiple points with youth with significant mental health needs and/or co-occurring substance use disorders. As increasing attention is paid to this issue by researchers, policy-makers, and juvenile justice administrators, mental health practitioners will be increasingly involved as key stakeholders in meeting the needs of these youth and participating in collaborative efforts to divert them from unwarranted penetration into the juvenile justice system. Mental health practitioners providing professional services to these youth and/or juvenile justice professionals will not ordinarily be adequately prepared by training and experience.

Mental health practitioners providing services to youth and/or juvenile justice professionals need to be able to: (a) distinguish between “treatment” and

“rehabilitation” in juvenile justice; (b) apply research and principles of developmental psychopathology in understanding youth with delinquent misconduct; (c) recognize and manage the complexities of differential diagnosis of the mental health disorders of youth in the juvenile justice system; (d) articulate any diagnostic or functional characteristics of a youth relevant to recidivism risks or protective factors, or relevant to addressing obstacles to non-mental health rehabilitation efforts; (e) incorporate evidence-based approaches and professional “best practices” in providing case-specific screening, assessments, case formulations, and interventions; (f) integrate a trauma-informed approach to screening, assessment, and intervention, and (g) demonstrate the ability to effectively collaborate in multidisciplinary and multi-system partnerships to meet the needs of youth, their families, and their communities.

Finally, mental health practitioners must be prepared to participate in identifying alternatives to juvenile justice approaches relying upon traditional punitive or mental health models. These alternatives will incorporate emerging research on adolescent psychological and brain development, adverse childhood experiences and trauma, effective assessment and empirically-based intervention practices, and collaborative partnerships. Properly prepared, mental health practitioners can be meaningful participants in crafting “systems” and youth-specific responses focused upon accountability for misconduct and personal decision-making, development of youth competencies, and use of community-based supports to prevent juvenile justice involvement, divert youth from unnecessary penetration into the juvenile justice system, reduce recidivism, and support positive development for youth with significant mental health needs at all points of contact with juvenile justice.

## Notes

---

- 1 In her presentation at the National Leadership Forum on Behavioral Health/Criminal Justice Services (Washington DC, April 5, 2001), SAMHSA Administrator Pamela S. Hyde noted that more than 80 percent of adult state inmates, 72 percent of federal inmates, and 82 percent of jail prisoners meet criteria for mental health or substance use disorders. She also state that more than 41 percent of state inmates, 28 percent of federal inmates, and 48 percent of jail inmates meet criteria for both.
- 2 See, for example: Report of the Texas Juvenile Probation Commission (2003) indicating that 67 percent of incarcerated youth with high mental health needs were committed for non-violent offenses.
- 3 See, for example: Congressional Committee on Government Reform (2004) reporting that approximately two-thirds of surveyed juvenile detention facilities indicate that they hold youth because of lack of available mental health services.
- 4 See, for example: Congressional Committee on Government Reform (2004) reporting that some 25% of juvenile detention facilities have poor mental health treatment or no mental health services for youth.
- 5 See, for example: Report of the US Department of Justice (2005) reporting on a series of investigations of secure juvenile facilities and documenting poor staff training, inadequate clinical services, improper medication practices.
- 6 See NCMHJJ's *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System* (Skowyra & Coccozza, 2007). The critical intervention points identified by the Blueprint For Change: (a) Initial Contact and Referral; (b) Intake; (c) Detention; (d) Judicial Processing; (e) Probation Supervision; or alternatively (f) Secure Placement; followed by (g) Re-Entry.
- 7 See, for example: SAMHSA's *Helping Young Offenders Return to the Community*, (Newsletter, 16(3): May/June 2008) for descriptions of model programs for community re-entry of juveniles, such as those funded by the Young Offender Reentry Program of SAMHSA's Center for Substance Abuse Treatment. See also: *Resource Kit: Improving Services for Youth with Mental Health and Co-Occurring Substance Use Disorders Involved with the Juvenile Justice System*. Available on the National Center for Mental Health and Juvenile Justice website.
- 8 Center for Mental Health Services (CMHS), SAMHSA. *Comprehensive Community Mental Health Services for Children and Their Families Program. Evaluation Findings: Annual Report to Congress (2005)*; CMHS, SAMHSA.

- Working Together to Help Youth Thrive in Schools and Communities: Systems of Care*. Publication: SMA10-4546 (May 2010).
- 9 Kinscherff, R. T. "Forensic Assessment of Amenability To Rehabilitation in Juvenile Delinquency." In SN Sparta and GP Koocher (Eds.) Forensic Mental Health Assessments of Children and Adolescents (Chap. 19, pp. 311-329). New York: Oxford University Press, 2006.
  - 10 *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (Text Revisions), Washington, D.C.: American Psychiatric Association, July 2000.
  - 11 Rogers, K. M., Pumariega, A. J., Atkins, D. L., & Cuffe, S. P. Conditions associated with Identification of Mentally Ill Youth in Juvenile Detention. *Community Mental Health Journal* (42) 1, February 2006.
  - 12 The diagnostic criteria of the DSM-IV TR diagnostic system are used in this discussion of diagnoses.
  - 13 The percentages of males and females cited in the following discussion of diagnostic categories are from Shufelt & Coccozza (2006) and specifically reflect results among youth involved with the juvenile justice system rather than community samples.
  - 14 Moreno, C., Laje, G. J., Blanco, C., Jiang, H., Schmidt, A. B., & Olfson, M. Outpatient trends in the diagnosis and treatment of bipolar disorder in youth. *Archives of General Psychiatry*; 2007, (64)9, 1032-1039.
  - 15 Biederman, J., Mick, E., Faraone, S. V., Spencer, T., Wilens, T. E., & Wozniak, J. Pediatric mania: A developmental subtype of bipolar disorder? *Biological Psychiatry*, September 2006, (48) 6, 458-466
  - 16 Assessment guidelines include: Practice parameters for the assessment and treatment of children, adolescents, and adults with attention-deficit/hyperactivity disorder. American Academy of Child and Adolescent Psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry* 36 (10 Suppl): 85S–121S.
  - 17 National Institute of Mental Health. Attention Deficit Hyperactivity Disorder, Complete Publication. Archived from the original on 2007-10-18. Available on at <http://web.archive.org/web/20071018052052/http://www.nimh.nih.gov/health/publications/adhd/complete-publication.shtml>.
  - 18 AACAP Official Action. Practice parameters for the assessment and treatment of children and adolescents with conduct disorder. *Journal of American Academy of Child and Adolescent Psychiatry*. 1997;36(suppl):122–39; Henggeler, S. W. & Borduin, C. M. (1990). Family Therapy and Beyond: A Multisystemic Approach to

- Treating the Behavior Problems of Children and Adolescents. Pacific Grove, CA: Brooks/Cole Pub Co.
- 19 Kinscherff, R. T. & Tobey, A. E. "Forensic Assessment in Juvenile Transfer Proceedings: Effects of Traumatic Stress and Chronic Violence." *Expert Opinion* (Newsletter of Division of Forensic Mental Health of the Massachusetts Department of Mental Health. Law and Psychiatry Program (University of Massachusetts Medical Center), 4 (2): 3-6, Spring 1996.
  - 20 Buffington, K., Dierkhising, C. B., & Marsh, S. C. (2010). *Technical Assistance Bulletin: Ten things every juvenile court judge should know about trauma and delinquency*. Reno, NV: National Council of Juvenile and Family Court Judges.
  - 21 Maschi, T., Bradley, C. A., & Morgen, K. (2008). Unraveling the link between trauma and delinquency: The mediating role of negative affect and delinquent peer exposure. *Youth Violence and Juvenile Justice* 6(2), 136-157.
  - 22 Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. Posttraumatic Stress Disorder and Trauma in Youth in Juvenile Detention. *Arch Gen Psychiatry*, 2004 (61):403–410.
  - 23 National Child Traumatic Stress Network (2008). Judges and child trauma: Findings from the National Traumatic Stress Network/National Council of Juvenile and Family Court Judges Focus Groups. *Service Systems Brief*, 2(2), 1-4.
  - 24 Mueser, K. T. & Taub, J. Trauma and PTSD Among Adolescents With Severe Emotional Disorders Involved in Multiple Service Systems. *Psychiatric Services* 59:627-634, June 2008.
  - 25 van der Kolk, B. A., Pynoos, R. S., et. al. (2009). *Proposal to Include A Developmental Trauma Diagnosis for Children and Adolescents in DSM-V*. National Child Traumatic Stress Network DSM-V Task Force.
  - 26 At the time of writing, it has been proposed for inclusion in the DSM-V revision due in 2013 but it is uncertain whether it will included.
  - 27 van der Kolk, B. A., Pynoos, R. S., et. al. (2009). *Proposal to Include A Developmental Trauma Diagnosis for Children and Adolescents in DSM-V*. National Child Traumatic Stress Network DSM-V Task Force.
  - 28 Ibid. These sorts of difficulties are categorized within the proposed Developmental Trauma Disorder diagnosis as (a) Affective and Physiological Dysregulation; (b) Attentional and Behavioral Dysregulation; (c) Self and Relational Dsyregulation; and (d) PTSD Spectrum Symptoms. Relevant functional impairments required for the diagnosis include arrests, detentions,

- probation violations, incarcerations, increasingly severe offenses and other legal difficulties.
- 29 Ibid.
- 30 See Pelaprat, M. *Complex Trauma Among Court-Involved Youth*. Doctoral Project, Massachusetts School of Professional Psychology, 2009. Of particular interest, this preliminary investigation relied upon assessments which did not include routine screening or assessment for dimensions of Developmental Trauma Disorder/“complex PTSD” and yet found that approximately 66% of the 41 youth whose cases were studied had experienced two or more forms of trauma exposure, and that dimensions of “complex” post-traumatic adaptation were found to be better descriptors of the youth than the formal PTSD diagnostic criteria, with two-thirds of youth showing clinical impairment on at least one “complex” posttraumatic dimension and some 50% showing clinical impairment in multiple dimensions.
- 31 van der Kolk, B.A. Developmental Trauma Disorder. *Psychiatric Annals*, 35, 5: May 2005.
- 32 Teicher, M. H., Andersen, S. L., Polcari, A., Anderson, C. M., & Navalta, C. P. (2002) Developmental neurobiology of childhood stress and trauma. *Child and Adolescent Psychiatric Clinics of North America*, 25:397–426,vii-viii; Perry, B. D. (2001) The neurodevelopmental impact of violence in childhood. In: Schetky D, Benedek EP (eds) Textbook of Child and Adolescent Forensic Psychiatry. Washington, DC: American Psychiatric Press, Inc, pp 221–238; Bremner, J. D. (2003) Long-term effects of childhood abuse on brain and neurobiology. *Child and Adolescent Psychiatric Clinics of North America*, 12:271–292.
- 33 Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174-186.
- 34 Koenen, K. C., Fu, Q. J., Lyons, M. J., Toomey, R., Goldberg, J., Eisen, S. A., True, W., & Tsuang, M. Juvenile conduct disorder as a risk factor for trauma exposure and posttraumatic stress disorder. *Journal of Traumatic Stress*, 18(1), 23–32, February 2005; Newman, E. Assessment of PTSD and Trauma Exposure in Adolescents. *Journal of Aggression, Maltreatment and Trauma*, 6(1), 2002.
- 35 Kerig, P. K. & Becker, S. P. From internalizing to externalizing: Theoretical models of the processes linking PTSD to juvenile delinquency. In S. J. Egan (Ed.), Posttraumatic stress disorder (PTSD): Causes, symptoms and treatment (pp. 33-78). Hauppauge, NY: Nova Science Publishers, 2010; Perry, P. D. & Hambrick, E. (2008). Introduction to the Neurosequential Model of Therapeutics. *Reclaiming Children and Youth*, 17, 38-43.

- 36 Ford, J.D., Chapman, J. F., Hawke, J., & Albert, D. (2007). *Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions*. Research and Program Brief. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- 37 Mahoney, K., Ford, J. D., Ko, S. J., & Siegfried, C. B. *Trauma-Focused Interventions for Youth in the Juvenile Justice System*. National Child Traumatic Stress Network (Juvenile Justice Working Group), 2004.
- 38 See Web site: Centers for Disease Control at <http://www.cdc.gov/ace/index.htm> for the Adverse Childhood Experiences Study.
- 39 Shilling, E. A., Aseltine Jr., R. A., & Gore, S. Adverse childhood experiences and mental health in young adults: A longitudinal survey. *BioMed Central Public Health*, 7(30): 2007. Available at <http://www.biomedcentral.com/471-2458/7/30>.
- 40 Griffin, G., Germain, E. J., & Wilkerson, R. G. Using a Trauma-Informed Approach in Juvenile Justice Institutions. *Journal of Child and Adolescent Trauma*, (in press) 5(3), September 2012.
- 41 Ibid.