Juvenile Justice Fact Sheet

MENTAL HEALTH NEEDS OF JUVENILE OFFENDERS

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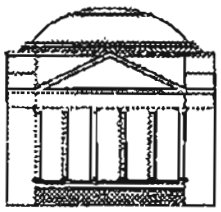

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Mental illness and substance abuse, which often co-occur among juvenile offenders, can contribute substantially to delinquent behavior. Studies have consistently found very high prevalence rates of mental illness among detained and incarcerated juveniles, and juvenile offenders generally. While estimates of the percentage of juvenile offenders who have mental health problems vary widely (e.g., between about 30-90%, depending upon what is included as a mental illness), most estimates are substantially higher than the roughly 20% prevalence rate found in the non-delinquent adolescent population. Indeed, many juvenile offenders have multiple mental health problems, and about 15-20% have a serious mental illness. Lack of appropriate treatment in adolescence may lead to further delinquency, adult criminality, and adult mental illness.

Psychosocial and environmental risk factors also contribute to juvenile offending. Frequently it is difficult to determine which mental illness or risk factor is the greater source of problems because juvenile offenders often have multiple mental illnesses and/or are exposed to multiple risk factors.

This fact sheet provides an overview of the mental health and psychosocial risk factors associated with juvenile offending.

COMMON MENTAL ILLNESSES AMONG JUVENILE OFFENDERS

Multiple diagnoses of mental illnesses ("comorbidity") are common among juvenile offenders; finding multiple disorders within a single adolescent is not uncommon. All 71 subjects in one study of seriously delinquent juveniles in detention were found to have

more than one diagnosis of mental illness. Another study found that 63.3% of incarcerated juveniles had two or more diagnoses of mental illness, along with a significantly higher prevalence of psychotic symptoms than a matched community sample.

The most common diagnoses for juvenile offenders are:

Conduct Disorder (CD); Oppositional Defiant Disorder (ODD)
Alcohol Dependence
Major Depression; Dysthymia
Attention Deficit Hyperactivity Disorder (ADHD)
Bipolar Disorder (Manic Depression)
Generalized Anxiety Disorder
Post-Traumatic Stress Disorder

The most common diagnosis for boys is Oppositional Defiant Disorder or Conduct Disorder, often with an additional diagnosis of ADHD and/or alcohol dependence.

The most common diagnosis for girls is Depression, often with an additional diagnosis of Oppositional Defiant Disorder and/or Alcohol Dependence.

Sadly, the multiple mental health needs of juvenile offenders are often unaddressed. For example, one follow-up study of 97 incarcerated male adolescents found that all but six had been rearrested as adults; most had never received treatment for their psychiatric disorders.

Identifying symptoms of mental illness that might interfere with functioning is necessary to rehabilitate the social, academic and occupational skills of juvenile offenders. Early identification and intervention is a priority, particularly with diagnoses that can lead to later offending. Boys tend to suffer from behavior disorders (Oppositional Defiant Disorder; Conduct Disorder) and ADHD, which often co-occur and contribute to delinquency. But these disorders can be treated with appropriate medication and/or appropriate psychosocial and behavioral interventions. Girls, on the other hand, tend to suffer from depression and substance abuse. These also can contribute significantly to delinquency but can be treated with medication and/or cognitive-behavioral treatment interventions. Additionally, youths suffering from psychotic symptoms, who are at risk for exploitation and assault while in correctional facilities as well as undue suffering, can be helped through appropriate psychiatric treatment.

CONDUCT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER

Behaviors associated with Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder (CD) are frequently blamed for juvenile offending. The two disorders co-occur so often that it is difficult to determine how much each disorder contributes to delinquent behavior. Thirty to fifty percent of adolescents diagnosed with ADHD also receive a diagnosis of CD, though the two disorders differ substantially.

Several studies of incarcerated juveniles found that 87-91% had Conduct Disorder (CD), which is not surprising given that CD is characterized by persistent violation of age-appropriate societal norms or rules or a disregard for the rights of other individuals. Examples of CD symptoms include aggression towards people or animals, destruction of property, theft or running away. Antisocial adolescents are different from other adolescents in the ways they think, perceive relationships, and relate to others. Teens with CD have limited problem-solving strategies because they are inflexible in thinking about problems and possible solutions. Aggressive adolescents tend to see hostile intentions in ambiguous social interactions, and are likely to respond with unanticipated aggression without provocation. Children with a diagnosis of CD demonstrate poor social skills, such as a lack

of empathy and a tendency to be impulsive, problems associated with the adult characteristics of psychopathy.

Attention Deficit Hyperactivity Disorder (ADHD) is characterized by symptoms of inattention (e.g., forgetfulness or disorganization), hyperactivity (e.g., fidgeting or talking excessively), or impulsivity (e.g., interrupting others' conversations). Adolescents with ADHD exhibit poor school performance, reduced participation in extracurricular activities, and poor social relationships. Children and adolescents with ADHD have limited problem-solving skills and difficulty paying attention. ADHD in adults is associated with other mental illness, incarceration, job failures, and marital problems.

Earlier research suggested that these two syndromes arose from the same underlying condition, even though they had different symptoms, especially since both diagnoses have been found to predict juvenile and adult criminal offending. But more recent studies suggest that the two diagnoses represent two distinct disorders, with ADHD relating more closely to cognitive and academic problems and CD relating more closely to delinquency in adolescence and antisocial personality disorder in adulthood.

Several medications have been shown to be effective in treating adolescents with ADHD, including antidepressants, clonidine, neuroleptics, dextroamphetamine, methylphenidate, and pemoline. (These medications have not traditionally been prescribed for behaviors of CD, though methylphenidate has been shown to effectively reduce most CD symptoms.) Other effective treatments for ADHD include psychosocial interventions, such as classroom based behavior modification, social skills training, cognitive skills training, and parent training/home-based interventions. Using more than one of these approaches along with medication appears to produce better results than medication alone or a single intervention.

Treatment of CD has generally been limited to non-pharmacological interventions. The dysfunction associated with conduct disorder is an integral part of a larger context of living conditions, such as poor housing and education or ineffective parenting skills. Cognitively based interventions appear to reduce antisocial and aggressive behaviors. Parent management training (PMT) teaches parents to respond consistently to children and to interrupt maladaptive interactional habits that maintain aggressive or antisocial behavior. It has demonstrated short-term effectiveness in promoting prosocial behaviors in children and in reducing maladaptive behaviors through effective discipline practices. Functional Family Therapy, which expands parent management training to include family therapy, is also effective. In particular, Multisystemic Treatment (MST), which additionally includes interventions with offenders in school and community settings, has been shown to be a highly effective intervention for the delinquent behaviors associated with CD. Juvenile offending, regardless of diagnostic status, is best thought of as a potentially chronic disorder requiring multiple, persistent interventions across numerous settings, rather than an acute condition that resolves after a brief intervention.

ADHD may interfere with the acquisition of basic academic skills and general intellectual functioning. CD leads to acting out behaviors that may result in juvenile justice involvement. Early conduct problems associated with CD predict offending as early as age 12-13 and difficulties with social and behavioral requirements in school settings. Juveniles having both ADHD and CD have lower intellectual functioning and poorer academic skills and enter the juvenile justice system earlier. The presence of both disorders results in earlier delinquency and more negative outcomes.

Some juveniles have only ADHD symptoms; some have only CD symptoms; and some have both ADHD and CD symptoms. Therefore, careful examination of each symptom is necessary for a good diagnosis of either of these disorders. Correct diagnosis requires a careful review of the symptoms that may belong to one or the

other diagnosis, or to both. Appropriate treatment for the presence of either disorder should include consideration of symptoms indicating the other disorder, and whether treatment for both disorders is indicated.

SUBSTANCE ABUSE

Substance abuse is a particular concern with juvenile offenders because it is a major risk factor for delinquency. Substance abuse often co-occurs with Conduct Disorder (particularly in boys) and Depression (particularly in girls), and among juveniles who have been victims of sexual abuse. Juveniles having Conduct Disorder or Depression who also abuse substances, are at far greater risk for delinquency. Substance abuse increases in severity with symptoms of Conduct Disorder and Depression, and the more diagnoses a juvenile has, the more likely he or she is to become a polysubstance abuser. When substance abuse occurs with Conduct Disorder, it may be a manifestation of the disorder. When it occurs with Depression or Anxiety, it may represent an attempt to self-medicate.

Substance abuse exacerbates problems associated with other psychological problems and puts adolescents at greater risk for violence and recidivism. Adolescents with conduct disorder who also abuse substances often progress to the more serious diagnosis of adult antisocial personality disorder, suggesting that the long-term societal costs are great. Early identification of substance abuse problems, and appropriate interventions, are critical in delinquency prevention and rehabilitation.

PSYCHOSOCIAL STRESSORS

Psychosocial and environmental stressors also contribute to the problems of juvenile offenders. The quality and quantity of parental support and supervision is especially important. Parental psychiatric problems, lack of parental support, and the absence of one or both parents from the home, all predict delinquency. Boys whose parents remarry while the boys are between the ages of 12 and 15 engage in more fighting and theft than their peers, and tend to have less parental supervision and less emotionally warm relationships with their parents.

Exposure to violence is another vulnerability found in juvenile offenders. Exposure to violence may make them more likely to perceive hostility in ambiguous situations, and to accept aggression as a normal part of interpersonal relationships. Family abuse and exposure to violence are the most significant predictors of juvenile violence when comparing delinquents with non-delinquents. The same holds true when comparing more violent and less violent youths. As compared with less violent juvenile offenders, more violent juveniles are more likely to have been severely physically abused, sometimes leaving them with injuries to the central nervous system that make it difficult to resist behaviors motivated by strong emotion or impulsivity.

Exposure to violence is also linked to Post-Traumatic Stress Disorder. Half of the youths in a California Youth Survey who met full criteria for Post-Traumatic Stress Disorder (32%) or partial criteria (20%) described witnessing an event of domestic violence as the traumatizing event associated with the disorder.

Adequate parental involvement, nurturance, and support serves as an important buffer protecting juveniles from delinquency. Parenting education programs, particularly those teaching effective discipline practices, may be effective in improving the quality and quantity of parental involvement. Prolonged exposure to serious violence (e.g., neighborhood shootings; domestic violence) may put juvenile offenders at risk for Post-Traumatic Stress Disorder. It also can result in learned responses to violence wherein the juvenile learns to accept aggression and aggressive responses as a normal part of interpersonal relationships, thus resulting

in delinquent behavior. These juveniles often benefit from interventions aimed at teaching them social problem solving skills.

SPECIAL EDUCATION NEEDS

The rate of learning disabilities and special education needs is much higher among juvenile delinquents than in the non-delinquent adolescent population. Up to 35% of incarcerated juveniles require special education services for learning disabilities. These needs are often longstanding, dating back to elementary school, but often they are undiagnosed, misdiagnosed, or untreated in the school system. One study found that many juvenile offenders had problems with reading (45%) and spelling (38%) by the second grade, problems with truancy (19%) by the fifth grade, and overall academic delay (50%) by junior high school. Male recidivists show greater impairments in reading, writing and math skills than do non-recidivist offenders.

However, neuropsychological studies examining the functional cognitive performance (i.e., memory, learning, and problem solving skills) of delinquents have produced mixed results. One study, for example, found that neuropsychological measures did not discriminate well between delinquents and status offenders. Another study found that neuropsychological impairment at age 13 was associated with early onset delinquency, but that poor neuropsychological performance was unrelated to delinquency which began in adolescence.

Education is often an essential part of rehabilitation, since school failure, low school achievement, and truancy are significant risk factors for delinquency. Educational rehabilitation and special education services are often needed for juvenile offenders, particularly in reading, writing and math. Juvenile justice personnel should be sensitive to the special education needs of juvenile offenders; frequently their poor school performance (which may lead to truancy) is due to undiagnosed, misdiagnosed, or unaddressed learning disabilities and special education needs.

DEPRESSION AND SUICIDE

Suicidal gestures and attempts can result in disability and death, especially when the attemptor underestimates the lethality of their own behavior. Boys with Conduct Disorder and Oppositional Defiant Disorder may be at somewhat higher risk for suicidal thought and behavior. Among white juvenile offenders, suicidal thoughts and behaviors are most often associated with Major Affective Disorders (e.g., Depression; Bipolar Disorder) and Borderline Personality Disorder. No particular diagnostic symptoms have been found to predict suicidal behavior in African-American juvenile offenders..

The association between depressive disorders and conduct disorders, two of the most common diagnoses in juvenile offenders, suggests that all professionals who work with offenders must be educated about the indicators of suicidality and be diligent in assessing suicidal thoughts, seriousness of plans, and access to weapons or other means of suicide.

GENDER DIFFERENCES

As the number of female juvenile offenders has risen, interest in the difference between boys and girls who offend has increased. The rate of mental illness in girl offenders is two to three times that found in boys. The rate of multiple diagnoses is also higher for girls than for boys.

As noted earlier, depression is a significant diagnostic concern for females juvenile offenders, even in the presence of other diagnoses. Sexual and physical abuse also are common problems for incarcerated girls. In a survey of adolescent detainees, 68% of girls

reported a history of sexual abuse and 73% reported a history of physical abuse. (The same study found that 46.8% of boys reported physical abuse and 9.9% reported sexual abuse, showing that males also suffer from significant abuse.) Sexually abused girls, however, are at a higher risk for suicidal thoughts and behavior.

Paranoid and psychotic symptoms, visual hallucinations, auditory hallucinations, or loose, rambling and illogical thought processes occur as frequently for both sexes. The rates of abnormal electroencephalograms and history of severe head injury are also comparable. Minor neurological abnormalities occur at about the same rates, but females have more major neurological abnormalities.

Because girls are more likely to have been abused and to suffer from depression, those who are referred to detention should be assessed as soon as possible for pregnancy, and for sexually transmitted diseases and depression, which respond quickly to appropriate treatment.

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