Mental Health Needs of Youth Processed in Juvenile vs. Adult Court

Quantum Units Education
Affordable. Dependable. Accredited.

www.quantumunitsed.com

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP
Working for Youth Justice and Safety
JUVENILE JUSTICE BULLETIN

September 2015

Robert L. Listenbee, Administrator

Beyond Detention

Even though research indicates that the majority of youth in the juvenile justice system have been diagnosed with psychiatric disorders, reports issued by the Surgeon General and the President's New Freedom Commission on Mental Health show that juvenile detainees often do not receive the treatment and services they need.

This bulletin series presents the results of the Northwestern Juvenile Project, the first large-scale, prospective longitudinal study of drug, alcohol, and psychiatric disorders in a diverse sample of juvenile detainees. Individual bulletins examine topics such as suicidal behaviors in youth in detention, posttraumatic stress disorder and trauma among this population, functional impairment in youth after detention, and barriers for youth who need to receive mental health services.

Nearly all detained youth eventually return to their communities and the findings presented in this series provide empirical evidence that can be used to better understand how to meet youth's mental health needs and provide appropriate services while in detention and after their release. The Office of Juvenile Justice and Delinquency Prevention hopes this knowledge will help guide innovative juvenile justice policy and create a better future for youth with psychiatric disorders in the justice system.

OJJDP

Detained Youth Processed in Juvenile and Adult Court: Psychiatric Disorders and Mental Health Needs

Jason J. Washburn, Linda A. Teplin, Laurie S. Voss, Clarissa D. Simon, Karen M. Abram, Gary M. McClelland, and Nichole D. Olson

Highlights

This bulletin presents results of a study of the prevalence of psychiatric disorders among youth transferred to adult criminal court compared with those processed in juvenile court. Key observations, findings, and recommendations include:

- Many youth are being transferred to adult criminal court, with males, African Americans, Hispanics, and older youth significantly more likely to be processed in adult criminal court than females, non-Hispanic whites, and younger youth (even after controlling for the current charge).
- The prevalence of one or more disorders among youth transferred to adult criminal court does not significantly differ from that among youth processed in juvenile court.
- Among youth processed in adult criminal court, those sentenced to prison had significantly greater odds than those who received a less severe sentence of having a disruptive behavior disorder, a substance use disorder, or co-occurring affective and anxiety disorders.
- Community and correctional systems must collaborate to identify and treat youth with psychiatric disorders who are transferred to adult criminal court. Youth who are transferred to adult criminal court and receive prison sentences should be considered a particularly high-risk group who are likely to require additional services.

JUVENILE JUSTICE BULLETIN

SEPTEMBER 2015

Detained Youth Processed in Juvenile and Adult Court: Psychiatric Disorders and Mental Health Needs

Jason J. Washburn, Linda A. Teplin, Laurie S. Voss, Clarissa D. Simon, Karen M. Abram, Gary M. McClelland, and Nichole D. Olson

All 50 states and the District of Columbia have legal mechanisms for trying juveniles as adults in criminal court (General Accounting Office, 1995; Griffin, 2003; OJJDP, 2012; Puzzanchera et al., 2003). Historically, most states transferred juveniles to adult criminal court primarily through judicial waiver. Juvenile court judges waived youth to criminal court on a case-by-case basis, considering both the charge and the characteristics of the individual youth (Griffin, 2003; Salekin, 2002; Snyder, Sickmund, and Poe-Yamagata, 2000). The number of youth transferred to the adult court through a judicial waiver nearly doubled from 1985 to 1994 (Puzzanchera and Kang, 2012), contributing to the 128-percent increase in the number of juveniles held in adult jails during that time period (Adams and Addie, 2010).

Today, more juveniles are transferred to the adult criminal court, using automatic transfers and prosecutorial direct-file procedures, than by judicial waiver (Griffin et al., 2011). Automatic transfers exclude juveniles from the jurisdiction of the juvenile court solely on the basis of the type of offense, criminal history, and age of the youth. Prosecutorial direct-file mechanisms allow prosecutors

ABOUT THIS SERIES

Studies in this series describe the results of statistical analyses of the Northwestern Juvenile Project, a longitudinal study of youth detained at the Cook County Juvenile Temporary Detention Center in Chicago, IL, between 1995 and 1998. The sample included 1,829 male and female detainees between ages 10 and 18. The data come from structured interviews with the youth.

Topics covered in the series include the prevalence of suicidal thoughts and behaviors among juvenile detainees, posttraumatic stress disorder and trauma within this population, functional impairment after detention (at work, at school, at home, or in the community), psychiatric disorders in youth processed in juvenile or adult court, barriers to mental health services, violent death among delinquent youth, and the prevalence of psychiatric disorders in youth after detention. The bulletins can be accessed from the Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) website, ojjdp.gov.

In addition to the funding that OJJDP provided, the research also was supported by the National Institute on Drug Abuse, the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, the Substance Abuse and Mental Health Services Administration (Center for Mental Health Services, Center for Substance Abuse Prevention, and Center for Substance Abuse Treatment), the Centers for Disease Control and Prevention (National Center for Injury Prevention and Control and National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention), the National Institutes of Health Office of Research on Women's Health, the National Institute on Minority Health and Health Disparities, the Office of Rare Diseases, the Office of Behavioral and Social Sciences Research, the U.S. Departments of Labor and Housing and Urban Development, the William T. Grant Foundation, and the Robert Wood Johnson Foundation. The John D. and Catherine T. MacArthur Foundation, the Open Society Foundations, and The Chicago Community Trust provided additional funds.

to determine when to file certain juvenile cases directly in criminal court. Juvenile court judges are precluded from exercising their discretion in both of these forms of transfer. By 2011, automatic transfers were available in 29 states and prosecutorial direct-file procedures were available in 15 states, accounting for 78.4 percent of transfers to adult criminal court (Griffin et al., 2011). The expansion of automatic transfers and prosecutorial direct-file mechanisms likely contributed to the 39-percent decline in the proportion of youth transferred to the adult court through the use of judicial waiver since its peak in 1994 (Adams and Addie, 2012). Given the substantial number of youth whose cases are filed in adult criminal court annually, accurate information on the prevalence of psychiatric disorders in this population is critical because youth with serious psychiatric disorders who are processed in adult criminal court have the right to receive treatment.

Recent studies indicate that a substantial proportion of juvenile detainees need mental health services (Cauffman, 2004) and that between one-half and two-thirds of these juveniles have one or more psychiatric disorders (Teplin et al., 2002; Wasserman et al., 2002). Another study using a screening instrument for mental health problems indicates that youth who are transferred to adult prison have higher rates of psychiatric symptoms than youth housed in juvenile facilities (Murrie et al., 2009). Yet, no study has examined how prevalent psychiatric disorders are among youth transferred to adult criminal court (referred to in this bulletin as "transferred youth"). Data on this topic is needed for several reasons.

Historically, transferred youth have disproportionately come from underserved sociodemographic groups, and numerous studies indicate that they are disproportionately male and from racial/ethnic minority groups (Austin, Johnson, and Gregoriou, 2000; Barnes and Franz, 1989; Bishop, 2000; Fagan, Forst, and Vivona, 1987; Hamparian et al., 1982; Kinder et al., 1995; Olson, 2005; Snyder, Sickmund, and Poe-Yamagata, 2000). Although these disparities have declined in the past decade, they persist (Adams and Addie, 2010). They are a significant concern because young men and adolescent youth from racial/ethnic minority groups are significantly less likely than female and non-Hispanic white youth to receive the mental health treatment they need, once they are detained (Teplin et al., 2005). Little is known, however, about racial/ethnic disparities in mental health needs among transferred youth.

A further disadvantage for transferred youth is that they often wait substantially longer for their cases to be adjudicated (that is, to receive a finding of guilt or innocence) than youth who remain in the juvenile system (Fagan, 1996; Myers, 2003; Rudman et al., 1986). They are also less likely to be released before adjudication than adults in the criminal court system (Rainville and Smith, 2003). Because they are incarcerated longer, transferred youth may be at greater risk for developing psychiatric problems than those held in juvenile detention for shorter periods. In particular, the conditions often associated with extended detention—separation from loved ones, crowding, and solitary confinement—may increase the risk of suicidal behavior among transferred youth (Gallagher and Dobrin, 2006; Marcus and Alcabes, 1993; Parent et al., 1994; Pogrebin, 1985).

In addition, findings from an experimental study suggest that, once in court, transferred youth face jurors who may be biased against them simply because they are being tried in an adult court. Where it exists, this bias increases the likelihood of a guilty verdict, boosts the jurors' confidence in the youth's guilt, and lowers the standard of proof for guilt (Tang and Nunez, 2003). Transferred youth are more likely to be convicted and to receive more stringent sentences than those processed in juvenile court (Myers, 2003; Podkopacz and Feld, 1996; Rainville and Smith, 2003; Strom, Smith, and Snyder, 1998). They are also more likely to receive more severe punishments than young adults facing similar charges in adult criminal court (Kurlychek and Johnson, 2004, 2010). Nearly 60 percent of all transferred youth charged with violent offenses are adjudicated to prison, compared with 26 percent of similarly charged young adults (Rainville and Smith, 2003). As a result, approximately 2,639 youth are housed in adult state prison facilities (Sabol and Couture, 2008), where they may not receive age-appropriate interventions (Woolard et al., 2005). Before age-appropriate interventions for youth in the adult correctional system can be developed and implemented, corrections personnel and treatment providers need to know which psychiatric disorders are most prevalent among these youth.

Despite the importance of this issue, the authors found only one study that examined psychiatric problems among transferred youth (Beyer, 2006). That study investigated only posttraumatic stress disorder (PTSD) and learning disorders, and it was based on one clinician's coding of diagnoses from 50 of his case records.

Therefore, the Northwestern Juvenile Project study reported here is the first large-scale investigation of psychiatric disorders among transferred youth. Using data from the Northwestern Juvenile Project (Teplin et al., 2002), the authors compared transferred youth with those processed in juvenile court, addressing the following questions:

- Do the demographic characteristics of transferred youth differ from those of youth processed in juvenile court?

- Do the psychiatric needs of transferred youth differ from those of youth processed in juvenile court?
- Do the psychiatric needs of transferred youth who were sentenced to prison differ from those of transferred youth who received less severe sentences?

Methods

This section provides a brief overview of the authors' methods. Additional detailed information on the methodology can be found in Abram et al. (2003) and Teplin et al. (2002).

Participants and Sampling Procedures

Participants were part of the Northwestern Juvenile Project (NJP), a longitudinal study of 1,829 youth (ages 10–18) arrested and detained between November 20, 1995, and June 14, 1998, at the Cook County Juvenile Temporary Detention Center (CCJTDC) in Chicago, IL. The random sample was stratified by gender, race/ethnicity (African American, non-Hispanic white, Hispanic, or other), age (10–13 years or 14 years and older), and legal status (processed in juvenile or adult court) to obtain enough participants to examine key subgroups (e.g., females, Hispanics, younger children).

The gender, age, and offense distributions of the CCJTDC detainees are similar to detained juveniles nationwide (Snyder and Sickmund, 2006). As in other urban facilities, most youth detained in the center belong to racial/ethnic minority groups. The CCJTDC population is 77.9 percent African American, 5.6 percent non-Hispanic white, 16 percent Hispanic, and 0.5 percent other racial/ethnic groups.

The authors chose the detention center in Cook County, which includes Chicago and surrounding suburbs, for three reasons:

- Nationwide, most juvenile detainees live in and are detained in urban areas (Pastore and Maguire, 2000).
- Cook County is ethnically diverse and has the third largest Hispanic population in the United States (U.S. Census Bureau, 2001). Studying this population is important because Hispanics are the largest minority group in the United States (U.S. Census Bureau, 2000).
- The detention center's size (daily census of approximately 650 youth and intake of 20 youth per day) ensured that a large enough pool of participants would be available.

Detainees were eligible to be sampled regardless of any psychiatric diagnoses, their state of drug or alcohol intoxication, or their fitness to stand trial. The youth were interviewed in a private area, almost always within 2 days of intake. Most interviews lasted 2 to 3 hours, depending on how many symptoms were reported.

Transfer to Adult Criminal Court in Illinois

In Illinois, the minimum age at which a juvenile can be transferred to adult criminal court is 13 years. At the time the data were collected, the juvenile court had jurisdiction over all youth 16 years and younger, unless they were transferred to an adult criminal court (Illinois Juvenile Justice Commission, 2010). The Illinois statute at that time specified six felony offenses for which youth were automatically transferred to adult criminal court for processing. Four of these offenses are violent offenses (first-degree murder, aggravated criminal sexual assault, armed robbery with a firearm, or aggravated vehicular hijacking with a firearm); the other two offenses are not (unlawful use of a weapon on or within 1,000 feet of school property, and delivery of a controlled substance in or within 1,000 feet of a school or public housing).

Measures

To determine diagnoses, the authors used the English- and Spanish-language versions of the Diagnostic Interview Schedule for Children Version 2.3 (DISC–2.3) (Schwab-Stone et al., 1996), which was the most recent version available at the time of the study. The DISC–2.3 assesses the presence of disorders from the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* (DSM–III–R) in interviewees within the past 6 months. Data collection for PTSD began 13 months

"Correctional systems cannot assume that assessment and treatment approaches used with youth in the general population will be effective with transferred youth."

after the study began because PTSD was not included in the DISC–2.3. PTSD was measured with the DISC–4.0 (Shaffer et al., 2000), which provided 12-month rates using *DSM–IV* criteria for PTSD. Data on PTSD diagnoses were examined by using a subsample of 898 participants. The subsample was composed of 532 males (59 percent) and 366 females (41 percent). It included 490 African American youth (55 percent), 154 non-Hispanic white youth (17 percent), 252 Hispanic youth (28 percent), and 2 youth of other racial/ethnic groups (less than 1 percent).

The authors included the following disorders:

- Affective disorders (major depression, dysthymia, mania, and hypomania).
- Anxiety disorders (generalized anxiety disorder, separation anxiety disorder, obsessive-compulsive disorder, overanxious disorder, PTSD, and panic disorder).
- Psychotic disorders.
- Disruptive behavior disorders (conduct disorder, attention-deficit/hyperactivity disorder [ADHD], and oppositional defiant disorder).
- Substance use disorders (alcohol, marijuana, and drugs other than marijuana).

Details of the special procedures implemented for determining psychotic disorders and ADHD have been reported previously (Teplin et al., 2002).

Data on arrest charges were obtained from intake records at the Cook County Juvenile Temporary Detention Center.

Final Sample for Analyses

The final sample was restricted to participants 13 years and older (N = 1,715) because juveniles younger than 13 are not eligible for processing in adult criminal court in Illinois (see "Transfer to Adult Criminal Court in Illinois"). The PTSD subsample consisted of 840 participants 13 years and older. The final sample of transferred youth totaled 275; it included 21 females and 254 males, 199 African Americans, 69 Hispanics, and 7 non-Hispanic whites. The sample of youth processed in juvenile court totaled 1,440, including 616 females and 824 males, 727 African Americans, 429 Hispanics, 280 non-Hispanic whites, and 4 participants who self-identified as an "other" race or ethnicity. The unweighted $M \pm SD$ (mean±standard deviation) age was 15.7±0.5 years for transferred youth and 15.0±1.2 years for youth processed in juvenile court.

Findings

Criminal Characteristics

Among the 275 transferred youth, 117 (43 percent) were charged with a violent felony, 213 (78 percent) were found guilty, and 139 (51 percent) were sentenced to prison. Among the 1,440 youth processed in the juvenile court, 281 (20 percent) were charged with a violent felony, 945 (65 percent) were "adjudicated delinquent" (the juvenile justice equivalent to being found guilty), and 8 (1 percent) were sentenced to prison. Compared with youth processed in juvenile court, significantly more transferred youth were charged with a violent felony, found guilty, and sentenced to prison.

Likelihood of Transfer to Criminal Court by Gender, Age, and Racial/Ethnic Subgroup

Table 1 (page 6) presents the unweighted demographic characteristics of the sample and the weighted proportions of transferred youth compared with youth processed in juvenile court by gender, racial/ethnic subgroup, and specific age group. As shown in table 1, males, youth from

Table 1. Demographic Characteristics of Arrested and Detained Youth and Their Likelihood of Transfer to Adult Criminal Court[a]

Characteristic	Total *N*	Youth Transferred to Adult Court (%)	Significant Comparisons ($p < .05$)
Gender			Male > female
Female	637	3	
Male	1,078	7	
Race/ethnicity			African American > non-Hispanic white
African American	926	7	African American > Hispanic
Hispanic	498	5	Hispanic > non-Hispanic white
Non-Hispanic white	287	2	
Other	4	0	
Age, y[b]			Older > younger
13	258	0	
14	217	<1	
15	498	8	
16	644	10	
17[c]	89	1	
18[c]	9	0	

[a] Percentages are weighted to reflect the demographic characteristics of the Cook County Juvenile Temporary Detention Center (CCJTDC). *N*s are unweighted.

[b] Each additional year of age (after age 13) corresponds to a 52-percent increase in the odds of being transferred to adult criminal court.

[c] In Illinois, detainees 17 years and older are housed in adult detention facilities. Detainees ages 17 and 18 were in CCJTDC only if they committed the index crime before age 17 or misrepresented their age.

Table 2. Psychiatric Disorders Among Arrested and Detained Youth Processed in Adult or Juvenile Court[a]

Disorder	Court Where Processed[b]	
	Adult (*N* = 275) %	Juvenile (*N* = 1,440) %
Any disorder	66	68
Any disorder except conduct disorder	64	62
Any affective disorder	22	20
Major depression	16	14
Dysthymia	12	13
Mania	3	2
Hypomania	1	2
Any anxiety disorder	24	22
Panic disorder	0	<1
Separation anxiety disorder	16	13
Overanxious disorder	9	7
Generalized anxiety disorder	8	7
Obsessive-compulsive disorder	10	8
Posttraumatic stress disorder[c]	8	12
Psychotic disorder	2	1
Any disruptive behavior disorder	41	44
Attention-deficit/hyperactivity disorder	9	8
Oppositional defiant disorder	15	15
Conduct disorder	37	38
Any substance use disorder	55	51
Alcohol use disorder	29	26
Marijuana use disorder	49	45
Other substance use disorder	2	3
Alcohol and drug use disorder	24	21

[a] Percentages are weighted to reflect the demographic characteristics of the Cook County Juvenile Temporary Detention Center. *N*s are unweighted.

[b] There were no significant differences between groups in prevalence rates of any of the listed disorders.

[c] Estimates for posttraumatic stress disorder were based on a subsample ($n = 840$).

racial/ethnic minority groups, and older youth had greater odds of being transferred to adult court than females, non-Hispanic whites, and younger youth. Furthermore, African American youth had greater odds of being transferred than Hispanic youth. When examining whether the results changed when the sample was controlled for those charged with a violent felony, the results did not change. Males, youth from racial/ethnic minority groups, and older youth still had significantly greater odds of being transferred to adult court than females, non-Hispanic whites, and younger youth.

Table 3. Co-occurring Psychiatric Disorders Among Arrested and Detained Youth Processed in Adult or Juvenile Court[a]

Co-occurring Disorder	Court Where Processed[b]	
	Adult (*N* = 275) %	Juvenile (*N* = 1,440) %
Affective disorder[c] and indicated co-occurring disorder		
Anxiety disorder[c]	15	12
Disruptive behavior disorder[c]	17	15
Substance use disorder[c]	19	13
Anxiety and disruptive behavior disorders[c]	11	10
Anxiety and substance use disorders	13	8
Disruptive behavior and substance use disorders	15	11
Anxiety disorder and indicated co-occurring disorder		
Disruptive behavior disorder	17	15
Substance use disorder	19	15
Disruptive behavior and substance use disorders	14	12
Disruptive behavior and substance use disorders	32	32
Total number of types of disorder		
≥2	43	43
≥3	22	19
4	10	7

[a] Percentages are weighted to reflect the demographic characteristics of the Cook County Juvenile Temporary Detention Center. *N*s are unweighted.

[b] There were no significant differences in prevalence rates of any of the listed co-occurring disorders between youth processed in juvenile court and youth transferred to adult court.

[c] Affective disorders include major depression, dysthymia, mania, and hypomania. Anxiety disorders include generalized anxiety disorder, separation anxiety disorder, obsessive-compulsive disorder, overanxious disorder, panic disorder, and posttraumatic stress disorder. Disruptive behavior disorders include conduct disorder, attention-deficit/hyperactivity disorder, and oppositional defiant disorder. Substance use disorders include alcohol use disorder, marijuana use disorder, and drug use disorders other than marijuana.

Psychiatric Disorders Among Youth Processed in Juvenile Versus Criminal Court

Next, the study compared the prevalence of specific psychiatric disorders (table 2) and co-occurring psychiatric disorders (table 3) among transferred youth and youth processed in juvenile court. No significant differences in the prevalence of specific disorders were found between the two groups; both had high rates of disorders.

As shown in table 3, no differences were found for any combination of co-occurring psychiatric disorders. Furthermore, the authors found no differences between transferred youth and youth processed in juvenile court in the number of specific disorders or the number of types of psychiatric disorders.

Table 4. Psychiatric Disorders Among Youth Processed in Adult Court Receiving a Prison Sentence or a Sentence Other Than Prison[a]

Disorder	Sentence		Significant Comparisons ($p < .05$)
	Prison (*N* = 139) %	Other (*N* = 132) %	
Any disorder	74	57	Prison > Other
Any disorder except conduct disorder	74	55	Prison > Other
Any affective disorder	26	17	
Major depression	18	14	
Dysthymia	15	8	
Mania	4	2	
Hypomania	2	0	
Any anxiety disorder[b]	28	19	
Separation anxiety disorder	19	13	
Overanxious disorder	10	9	
Generalized anxiety disorder	8	8	
Obsessive-compulsive disorder	14	6	
Posttraumatic stress disorder[c]	3	14	
Psychotic disorder	3	1	
Any disruptive behavior disorder	50	32	Prison > Other
Attention-deficit/ hyperactivity disorder	8	10	
Oppositional defiant disorder	20	9	Prison > Other
Conduct disorder	46	28	Prison > Other
Any substance use disorder	65	45	Prison > Other
Alcohol use disorder	39	19	Prison > Other
Marijuana use disorder	60	39	Prison > Other
Other substance use disorder	2	2	
Alcohol and drug use disorders	34	14	Prison > Other

[a] Percentages are weighted to reflect the demographic characteristics of the Cook County Juvenile Temporary Detention Center. *N*s are unweighted. Sentencing data were missing for four participants, and they were excluded from these analyses.

[b] Panic disorder was excluded because no youth processed in adult court had this disorder.

[c] Estimates for posttraumatic stress disorder were based on a subsample (*n* = 142).

Psychiatric Disorders Among Youth Processed in Adult Court Receiving a Prison Sentence or a Sentence Other Than Prison

Prevalence rates of psychiatric disorders among those who did and did not receive a prison sentence were compared

among the 275 youth who were transferred. Table 4 shows the prevalence rates of specific psychiatric disorders. Transferred youth who received a prison sentence had significantly greater odds of having any disorder, any disorder except conduct disorder, any disruptive behavior disorder, oppositional defiant disorder, conduct disorder, any substance use disorder, alcohol use disorder, marijuana use disorder, and co-occurring alcohol and drug use disorders.

Table 5 shows the prevalence rates of co-occurring disorders among transferred youth by prison status (sentenced to prison or not). Transferred youth who received a prison sentence had significantly greater odds for having nearly all combinations of co-occurring disorders. Compared with transferred youth who did not receive a prison sentence, those who received a sentence had significantly greater odds of having two or more, three or more, and all four types of disorders. Finally, transferred youth who received a prison sentence had significantly greater numbers of specific disorders and significantly more types of disorders than those who did not receive a prison sentence.

Discussion of Findings

Diagnoses and Need for Psychiatric Treatment Among Transferred Youth Compared With Youth Processed in Juvenile Court and Adults in Detention

The study's findings indicate that the prevalence of one or more psychiatric disorders is as high for transferred youth as for youth processed in juvenile court. These findings are consistent with the clinical data reported by Beyer (2006), who found no differences on a clinical assessment between transferred youth and youth processed in juvenile court. The study reported in this bulletin provides the first systematic empirical evidence that many transferred youth, like their peers processed in juvenile court, have a substantial need for psychiatric and substance abuse services.

Table 5. Co-occurring Psychiatric Disorders Among Youth Processed in Adult Court Receiving a Prison Sentence or a Sentence Other Than Prison[a]

Co-occurring Disorder	Sentence		Significant Comparisons ($p < .05$)
	Prison (N = 139) %	Other (N = 132) %	
Affective disorder[b] and indicated comorbid disorder			
Anxiety disorder[b]	21	9	Prison > Other
Disruptive behavior disorder[b]	22	13	
Substance use disorder[b]	24	14	Prison > Other
Anxiety and disruptive behavior disorders	16	7	Prison > Other
Anxiety and substance use disorders	19	7	Prison > Other
Disruptive behavior and substance use disorders	19	11	
Anxiety disorder and indicated comorbid disorder			
Disruptive behavior disorder	21	13	
Substance use disorder	24	13	Prison > Other
Disruptive behavior and substance use disorders	17	9	
Disruptive behavior and substance use disorders	42	22	Prison > Other
Total number of types of disorder			
≥2	52	33	Prison > Other
≥3	28	16	Prison > Other
4	15	6	Prison > Other

[a] Percentages are weighted to reflect the demographic characteristics of the Cook County Juvenile Temporary Detention Center. *N*s are unweighted. Sentencing data were missing for four participants, and they were excluded from these analyses.

[b] Affective disorders include major depression, dysthymia, mania, and hypomania. Anxiety disorders include generalized anxiety disorder, separation anxiety disorder, obsessive-compulsive disorder, overanxious disorder, panic disorder, and posttraumatic stress disorder. Disruptive behavior disorders include conduct disorder, attention-deficit/hyperactivity disorder, and oppositional defiant disorder. Substance use disorders include alcohol use disorder, marijuana use disorder, and drug use disorders other than marijuana.

"Transferred youth may have a greater need for psychiatric services than detained adults."

These findings also suggest that transferred youth may have a greater need for psychiatric services than detained adults. Previous research indicates that less than 35 percent of detained adult males have a psychiatric disorder (excluding antisocial personality disorder) (Teplin, 1994); in contrast, 64 percent of transferred youth have a psychiatric disorder, even when conduct disorder is excluded. This study found that the 6-month prevalence rate of major depression for transferred youth (16 percent) was three times greater than the rate of depression over a lifetime as reported by adult male detainees (5 percent) (Teplin, 1994).

This study replicates previous findings that transferred youth are disproportionately male, African American, Hispanic, and older. Although these findings underscore the importance of addressing disproportionate confinement of individuals from minority groups (Hsia, Bridges, and McHale, 2004), the findings also have implications for psychiatric services. The sociodemographic factors associated with greater odds of being processed in adult criminal court are the same factors associated with lower odds of receiving psychiatric services, regardless of need (Teplin et al., 2005). This finding suggests that an urgent situation exists within the prison system; that is, the largest numbers of transferred youth who need psychiatric services are also the least likely to receive them.

The study also found that the odds of having a psychiatric disorder were greater among transferred youth sentenced to prison than those who received less severe sentences. The specific disorders associated with increased odds for a prison sentence were disruptive behavior and substance use disorders. Higher rates of disruptive behavior and substance use disorders may reasonably be expected among youth with more antisocial traits, assuming that a prison sentence is a proxy for more antisocial behavior. In other words, disruptive behavior and substance use disorders may reflect underlying antisocial traits. A parallel result has been found among adult male prisoners, of whom approximately half meet criteria for antisocial personality disorder (Fazel and Danesh, 2002).

The higher prevalence of co-occurring disorders found among prison-bound youth, however, is less easily explained by underlying antisocial traits. On average, transferred youth who were sentenced to prison had more than one psychiatric disorder, and 15 percent had all four major types of psychiatric disorders. Furthermore, the types of disorders were not limited to behavioral or substance use disorders; receiving a prison sentence was also associated with greater odds of having co-occurring affective and anxiety disorders. These findings suggest that transferred youth sentenced to prison have not only greater needs for behavioral rehabilitation to address disruptive behavior and substance use disorders than transferred youth who receive less severe sentences but also greater needs for psychiatric treatment of major affective and anxiety disorders.

Study Limitations

This study has several limitations. Because the findings are drawn from a single site, they may pertain only to detention centers with a demographic composition and legal mechanisms for transfer to adult criminal court that are similar to those at CCJTDC. For example, these findings may be generalized only to states that limit the juvenile court's jurisdiction to youth ages 16 and younger; most states extend their juvenile court's jurisdiction to age 18. Differences in the prevalence of disorders by transfer status may vary if diagnoses are based on later editions of the *DSM* than the *DSM–III–R*. Because it was not feasible to interview caretakers (few would have been available), the diagnostic data are also limited by the reliability and validity of youth's reports of their own behavior. This may result in underreporting of some disorders, such as disruptive behavior disorders. In addition, the sample size for specific sociodemographic groups, such as non-Hispanic white females, may be too small for reliable

comparisons with other states. The findings may apply less to areas with different mechanisms for transferring juveniles to adult criminal court.

Directions for Future Research

The following directions are suggested for future research.

Conduct Studies of Long-Term Functioning and Outcomes for Transferred Youth

Although several studies have examined recidivism among transferred youth (Bishop et al., 1996; Fagan, 1996; Myers, 2001; Podkopacz and Feld, 1996; Redding, 2010; Winner et al., 1997), little is known about the long-term effects for broader indications of functioning on individuals who have been processed in adult criminal court. Findings from this study suggest that youth processed in adult criminal court may experience worse long-term psychiatric outcomes than youth processed in juvenile court; however, few empirical studies are available. Longer stays in preadjudication detention and the stressors associated with processing in adult criminal court may increase the risk of psychiatric disorders and other adverse developmental, social, and functional consequences for transferred youth (Bishop and Frazier, 2000; Forst, Fagan, and Vivona, 1989; Penney and Moretti, 2005; Redding, 2003). Furthermore, previous studies have found that even within the juvenile court system, few youth receive the psychiatric services they need before they are adjudicated (Teplin et al., 2005), and the likelihood that transferred youth will receive the services they need after their adjudication is slim (Mulvey, Schubert, and Chung, 2007). With most transferred youth likely to complete their sentences and be released or to be returned to their communities on parole, data on the long-term psychiatric and overall functioning of this population are especially needed.

Conduct Studies of Competency To Stand Trial

Future studies should investigate the influence of psychiatric disorders on competency to stand trial among youth transferred to adult criminal court. Some states are beginning to recognize cognitive and developmental immaturity as a basis for incompetence similar to mental illness and mental retardation (Poythress et al., 2006). Although research indicates that adolescents as young as 16 years have, on average, abilities for judicial competency that are similar to those of adults (Bishop and Frazier, 2000; Poythress et al., 2006), more research is needed to understand how psychiatric disorders interact with the developmental stages that youth progress through and how they affect a youth's ability to participate in adult legal proceedings.

Implications for the Juvenile Justice System

Provide Diagnosis and Treatment for Transferred Youth

Psychiatric services within correctional systems must address the needs and characteristics of transferred youth; however, correctional systems are not yet prepared to identify and treat transferred youth who have psychiatric disorders (Woolard et al., 2005). Assessment and treatment approaches developed for use with adults cannot be applied automatically to transferred youth (Woolard et al., 2005), so correctional psychiatric systems must use developmentally, culturally, and contextually appropriate assessment and treatment approaches (Penney and Moretti, 2005). Because little is known about the effectiveness of treatments delivered to youth in correctional facilities (Grisso, 2004), correctional systems cannot assume that assessment and treatment approaches used with youth in the general population will be effective with transferred youth (Woolard et al., 2005). It is essential to correctly identify and treat psychiatric disorders in correctional settings to better serve not only the transferred youth themselves but also the communities to which they will return after serving their sentences.

Determine Whether Psychiatric Disorders Should Play a Mitigating Role in Transfer Decisions

Judicial processing, particularly the decision to process youth as adults or juveniles, provides a critical opportunity to intervene in a juvenile's life (Skowyra and Cocozza, 2007). Clinicians can advise the court about which youth may benefit from alternative sentencing options and which youth may be more likely or less likely to benefit from rehabilitation (Grisso, 2000). If alternative sentencing options are made available, prison sentences may become less common (Steiner, 2005). Clinicians and researchers must continue to refine juvenile assessment technology to help courts weigh mitigating psychiatric factors in transfer decisions (Brannen et al., 2006; Penney and Moretti, 2005). Unfortunately, although public opinion generally supports considering mitigating factors when making transfer decisions (Nunez et al., 2007), jurisdictions that have automatic transfer systems make this impossible.

Address Racial and Ethnic Disparities in the Transfer Process

The field must continue to address ongoing racial/ethnic disproportionality associated with the transfer process. According to the study's findings and national statistics, more than 60 percent of transferred youth with psychiatric problems are from racial/ethnic minority groups (Sickmund, Sladky, and Kang, 2008); these youth are most likely to be underserved in detention and in the community (Teplin et al., 2005). The disproportionate transfer of African American youth to adult court is of particular concern.

More locally, this study revealed metrics for CCJTDC that clearly show that minority youth in Cook County are disproportionately transferred to adult criminal court—84 percent of transferred youth were African American, but only 26 percent of Cook County's population is African American. Some states have already begun to address the influence of transfer processing on racial/ethnic disproportionality, and considerable gains have been made (Adams and Addie, 2010). For example, Illinois repealed two laws enacted in 1989 that required automatic transfer of youth older than 14 years to adult criminal court if they were charged with selling drugs within 1,000 feet of a designated "safe zone," typically schools and public housing. Because of the dense concentration of both schools and public housing in urban areas where racial/ethnic minority groups make up a large portion of the population, 99 percent of the youth transferred to adult criminal court for a drug crime were from racial/ethnic minority groups (Kooy, 2001).

Conclusion

Male, African American, Hispanic, and older youth had greater odds of being processed in adult criminal court than female, non-Hispanic white, and younger youth, even after adjusting for felony-level violent crime. Among youth processed in adult criminal court, 66 percent had at least one psychiatric disorder and 43 percent had two or more disorders. The prevalence and number of co-occurring disorders for youth processed in adult criminal court were similar to those processed in juvenile court. Among youth processed in adult criminal court, those sentenced to prison had significantly greater odds than those receiving a less severe sentence of having a disruptive behavior disorder, a substance use disorder, or co-occurring affective and anxiety disorders.

The transfer of youth to adult criminal court should be reserved for the most serious, chronic, and violent offenders (Penney and Moretti, 2005). Clinicians can help to ensure this outcome by determining when and how

mitigating psychiatric factors should be considered and which transferred youth may respond best to alternative sentencing. Correctional systems as well must provide psychiatric services to transferred youth, especially to youth sentenced to prison, and community health systems must continue services for these youth when they are released into the community. Whether part of the corrections or community systems, psychiatric service providers need to consider the disproportionate number of individuals from racial/ethnic minority groups who are transferred to adult criminal court when they are developing and implementing services.

For More Information

This bulletin was adapted from Washburn, J.J., Teplin, L.A., Voss, L.S., Simon, C.D., Abram, K.M., and McClelland, G.M. 2008. Psychiatric disorders among detained youths: A comparison of youths processed in juvenile court and adult criminal court. *Psychiatric Services* 59:965–973.

References

Abram, K.A., Teplin, L.A., McClelland, G., and Dulcan, M.K. 2003. Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 60(11):1097–1108.

Adams, B., and Addie, S. 2010. *Delinquency Cases Waived to Criminal Court, 2007*. Fact Sheet. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Adams, B., and Addie, S. 2012. *Delinquency Cases Waived to Criminal Court, 2009*. Fact Sheet. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Austin, J., Johnson, K.D., and Gregoriou, M. 2000. *Juveniles in Adult Prisons and Jails: A National Assessment.* Report. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Barnes, C.W., and Franz, R.S. 1989. Questionably adult: Determinants and effects of the juvenile waiver decision. *Justice Quarterly* 6(1):117–135.

Beyer, M. 2006. Fifty delinquents in juvenile and adult court. *American Journal of Orthopsychiatry* 76(2):206–214.

Bishop, D.M. 2000. Juvenile offenders in the adult criminal justice system. *In Crime and Justice: A Review of Research,* Vol. 27, edited by M. Tonry. Chicago, IL: University of Chicago, pp. 81–167.

Bishop, D.M., and Frazier, C.E. 2000. Consequences of transfer. In *The Changing Borders of Juvenile Justice: Transfer of Adolescents to the Criminal Justice System,* edited by J. Fagan and F.E. Zimring. Chicago, IL: University of Chicago Press, pp. 227–276.

Bishop, D.M., Frazier, C.E., Lanza-Kaduce, L., and Winner, L. 1996. The transfer of juveniles to criminal court: Does it make a difference? *Crime & Delinquency* 42(2):171–191.

Brannen, D.N., Salekin, R.T., Zapf, P.A., Salekin, K.L., Kubak, F.A., and DeCoster, J. 2006. Transfer to adult court: A national study of how juvenile court judges weigh pertinent Kent criteria. *Psychology, Public Policy, and Law* 12(3):332–355.

Cauffman, E. 2004. A statewide screening of mental health symptoms among juvenile offenders in detention. *Journal of the American Academy of Child and Adolescent Psychiatry* 43(4): 430–439.

Fagan, J. 1996. The comparative advantage of juvenile versus criminal court sanctions on recidivism among adolescent felony offenders. *Law and Policy* 18:77–113.

Fagan, J., Forst, M., and Vivona, T.S. 1987. Racial determinants of the judicial transfer decision: Prosecuting violent youth in criminal court. *Crime & Delinquency* 33:259–286.

Fazel, S., and Danesh, J. 2002. Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet* 359(9306):545–550.

Forst, M., Fagan, J., and Vivona, T.S. 1989. Youth in prisons and training schools: Perceptions and consequences of the treatment custody dichotomy. *Juvenile & Family Court Journal* 39:1–14.

Gallagher, C.A., and Dobrin, A. 2006. Deaths in juvenile justice residential facilities. *Journal of Adolescent Health* 38(6):662–668.

General Accounting Office. 1995. *Juvenile Justice: Juveniles Processed in Criminal Court and Case Dispositions Report.* Washington, DC: U.S. General Accounting Office.

Griffin, P. 2003. *Trying and Sentencing Juveniles as Adults: An Analysis of State Transfer and Blended Sentencing Laws.* Bulletin. Pittsburgh, PA: National Center for Juvenile Justice.

Griffin, P., Addie, S., Adams, B., and Firestine, K. 2011. *Trying Juveniles as Adults: An Analysis of State Transfer Laws and Reporting.* Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Grisso, T. 2000. Forensic clinical evaluations. In *The Changing Borders of Juvenile Justice: Transfer of Adolescents to the Criminal Justice System,* edited by J. Fagan and F.E. Zimring. Chicago, IL: University of Chicago Press, pp. 321–352.

Grisso, T. 2004. *Double Jeopardy: Adolescent Offenders with Mental Disorders.* Chicago, IL: University of Chicago Press.

Hamparian, D.M., Estep, L.K., Muntean, S.M., Priestino, R.R., Swisher, R.G., Wallace, P.L., et al. 1982. *Youth in Adult Court: Between Two Worlds.* Columbus, OH: Academy for Contemporary Problems.

Hsia, H.M., Bridges, G.S., and McHale, R. 2004. *Disproportionate Minority Confinement: 2002 Update.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Illinois Juvenile Justice Commission. 2010. *Policies and Procedures of the Illinois Juvenile Justice System.* Chicago, IL: Illinois Criminal Justice Information Authority. Available online: www.icjia.state.il.us/public/pdf/ResearchReports/IL_Juvenile_Justice_System_Walkthrough_0810.pdf.

Kinder, K., Veneziano, C., Fichter, M., and Azuma, H. 1995. A comparison of the dispositions of juvenile offenders certified as adults with juvenile offenders not certified. *Juvenile & Family Court Journal* 46:37–42.

Kooy, E. 2001. *The Status of Automatic Transfers to Adult Court in Cook County, Illinois: October 1999 to September 2000.* Chicago, IL: Juvenile Transfer Advocacy Unit.

Kurlychek, M., and Johnson, B. 2004. The juvenile penalty: A comparison of juvenile and young adult sentencing outcomes in criminal court. *Criminology* 42:485–517.

Kurlychek, M., and Johnson, B.D. 2010. Juvenility and punishment: Sentencing juveniles in adult criminal court. *Criminology* 48(3):725–758.

Marcus, P., and Alcabes, P. 1993. Characteristics of suicides by inmates in an urban jail. *Hospital & Community Psychiatry* 44(3):256–261.

Mulvey, E.P., Schubert, C.A., and Chung, H.L. 2007. Service use after court involvement in a sample of serious adolescent offenders. *Children and Youth Services Review* 29(4):518–544.

Murrie, D.C., Henderson, C.E., Vincent, G.M., Rockett, J.L., and Mundt, C. 2009. Psychiatric symptoms among juveniles incarcerated in adult prison *Psychiatric Services* 60(8): 1092–7.

Myers, D.L. 2001. *Excluding Violent Youths from Juvenile Court: The Effectiveness of Legislative Waiver.* New York, NY: LFB Scholarly Publishing LLC.

Myers, D.L. 2003. Adult crime, adult time: Punishing violent youth in the adult criminal justice system. *Youth Violence and Juvenile Justice* 1(2):173–197.

Nunez, N., Dahl, M.J., Tang, C.M., and Jensen, B.L. 2007. Trial venue decisions in juvenile cases: Mitigating and extralegal factors matter. *Legal and Criminological Psychology* 12(1):21–39.

Office of Juvenile Justice and Delinquency Prevention. 2012. *Statistical Briefing Book*. Available online: www.ojjdp.gov/ojstatbb/structure_process/qa04115.asp?qaDate=2011. Released on December 17, 2012.

Olson, J.K. 2005. Waiver of juveniles to criminal court: Judicial discretion and racial disparity. *Justice Policy Journal* 2(1):1–20.

Parent, D.G., Leiter, V., Kennedy, S., Livens, L., Wentworth, D., and Wilcox, S. 1994. *Conditions of Confinement: Juvenile Detention and Corrections Facilities.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Pastore, A.L., and Maguire, K. 2000. *Sourcebook of Criminal Justice Statistics—1999*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Penney, S.R., and Moretti, M.M. 2005. The transfer of juveniles to adult court in Canada and the United States: Confused agendas and compromised assessment procedures. *International Journal of Forensic Mental Health* 4(1):19–37.

Podkopacz, M.R., and Feld, B.C. 1996. The end of the line: An empirical study of judicial waiver. *Journal of Criminal Law & Criminology* 86:449–492.

Pogrebin, M. 1985. Jail and the mentally disordered: The need for mental health services [Empirical article]. *Journal of Prison and Jail Health* 5(1):13–19.

Poythress, N., Lexcen, F.J., Grisso, T., and Steinberg, L. 2006. The competence-related abilities of adolescent defendants in criminal court. *Law and Human Behavior* 30(1):75–92.

Puzzanchera, C., and Kang, W. 2012. Easy Access to Juvenile Court Statistics: 1985–2009. Washington,DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Available online: www.ojjdp.gov/ojstatbb/ezajcs.

Puzzanchera, C., Stahl, A., Finnegan, T.A., Tierney, N., and Snyder, H.N. 2003. *Juvenile Court Statistics 1999.* Bulletin. Washington. DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Rainville, G.A., and Smith, S.K. 2003. *Juvenile Felony Defendants in Criminal Court*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Redding, R.E. 2003. The effects of adjudicating and sentencing juveniles as adults: Research and policy implications. *Youth Violence and Juvenile Justice* 1(2):128–155.

Redding, R.E. 2010. *Juvenile Transfer Laws: An Effective Deterrent to Delinquency?* Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Rudman, C., Hartstone, E., Fagan, J., and Moore, M. 1986. Violent youth in adult court: Process and punishment. *Crime & Delinquency* 32:75–96.

Sabol, W.J., and Couture, H. 2008. *Prison Inmates at Midyear 2007*. Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Salekin, R.T. 2002. Juvenile transfer to adult court: How can developmental and child psychology inform policy decision making? In *Children, Social Science, and the Law,* edited by B.L. Bottoms and M. Bull Kovera. New York, NY: Cambridge University Press, pp. 203–232. Available online: http://site.ebrary.com.turing.library.northwestern.edu/lib/northwestern/Doc?id=10023385.

Schwab-Stone, M.E., Shaffer, D., Dulcan, M.K., Jensen, P.S., Fisher, P., Bird, H.R., et al. 1996. Criterion validity of the NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC–2.3). *Journal of the American Academy of Child and Adolescent Psychiatry* 35(7):878–888.

Shaffer, D., Fisher, P., Lucas, C.P., Dulcan, M.K., and Schwab-Stone M.E. 2000. NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC–IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry* 39(1):28–38.

Sickmund, M., Sladky, T.J., and Kang, W. 2008. Census of Juveniles in Residential Placement Databook. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Available online: www.ojjdp.gov/ojstatbb/ezacjrp.

Skowyra, K.R., and Cocozza, J.J. 2007. *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*. Delmar, NY: National Center for Mental Health and Juvenile Justice, Policy Research Associates, Inc.

Snyder, H.N., and Sickmund, M. 2006. *Juvenile Offenders and Victims: 2006 National Report*. Report. Washington, DC: Office of Justice Programs, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Snyder, H.N., Sickmund, M., and Poe-Yamagata, E. 2000. *Juvenile Transfers to Criminal Court in the 1990s: Lessons Learned from Four Studies*. Report. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Steiner, B. 2005. Predicting sentencing outcomes and time served for juveniles transferred to criminal court in a rural northwestern state. *Journal of Criminal Justice* 33(6):601–610.

Strom, K.J., Smith, S.K., and Snyder, H.N. 1998. *Juvenile Felony Defendants in Criminal Courts: State Court Processing Statistics, 1990–1994*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Tang, C.M., and Nunez, N. 2003. Effects of defendant age and juror bias on judgment of culpability: What happens when a juvenile is tried as an adult? *American Journal of Criminal Justice* 28(1):37–52.

Teplin, L.A. 1994. Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health* 84(2):290–293.

Teplin, L.A., Abram, K.M., McClelland, G.M., Dulcan, M.K., and Mericle, A.A. 2002. Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 59(12):1133–1143.

Teplin, L.A., Abram, K.M., McClelland, G.M., Washburn, J.J., and Pikus, A.K. 2005. Detecting mental disorder in juvenile detainees: Who receives services? *American Journal of Public Health* 95(10):1773–1780.

U.S. Census Bureau. 2000. *Census 2000 Profiles of General Demographic Characteristics: National Summary & Special Packages*. Washington, DC: U.S. Department of Commerce, U.S. Census Bureau. Available online: http://factfinder2.census.gov.

U.S. Census Bureau. 2001. *The Hispanic Population*. Washington, DC: U.S. Department of Commerce, U.S. Census Bureau.

Wasserman, G.A., McReynolds, L.S., Lucas, C.P., Fisher, P., and Santos, L. 2002. The voice DISC–IV with incarcerated male youths: Prevalence of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 41(3):314–321.

Winner, L., Lanza-Kaduce, L., Bishop, D.M., and Frazier, C.E. 1997. The transfer of juveniles to criminal court: Reexamining recidivism over the long term. *Crime & Delinquency* 43(4):548–563.

Woolard, J.L., Odgers, C., Lanza-Kaduce, L., and Daglis, H. 2005. Juveniles within adult correctional settings: Legal pathways and developmental considerations. *International Journal of Forensic Mental Health* 4(1):1–18.

Acknowledgments

Jason J. Washburn, Ph.D., ABPP, is Assistant Professor and Director of Education and Clinical Training in the Division of Psychology, Department of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine, Northwestern University, Chicago, IL. He is also Director of the Center for Evidence-Based Practice at Alexian Brothers Behavioral Health Hospital, Hoffman Estates, IL.

Linda A. Teplin, Ph.D., is the Owen L. Coon Professor and Vice Chair for Research in the Department of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine, Northwestern University, Chicago, IL, as well as Director of the Department's Program in Health Disparities and Public Policy.

Laurie S. Voss, Ph.D., is Managing Principal and Global Lead Executive Coaching, Korn/Ferry International, Durango, CO.

Clarissa D. Simon, Ph.D., is an Adjunct Professor in the School of Education and Social Policy, Northwestern University, Evanston, IL. She is also a Research Consultant in the Department of Medical and Social Sciences at the Feinberg School of Medicine, Northwestern University, Chicago, IL.

Karen M. Abram, Ph.D., is Associate Professor and Associate Director, Health Disparities and Public Policy, in the Department of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine, Northwestern University, Chicago, IL.

Gary M. McClelland, Ph.D., is Research Assistant Professor in Psychiatry and Behavioral Sciences, Feinberg School of Medicine, Northwestern University, Chicago, IL.

Nichole D. Olson, Ph.D., is a postdoctoral fellow in the Department of Psychiatry, Stanford School of Medicine, Stanford, CA.

The study on which this bulletin is based could not have been accomplished without the advice of Ann Hohmann, Ph.D., Kimberly Hoagwood, Ph.D., Heather Ringeisen, Ph.D., Grayson Norquist, M.D., and Delores Parron, Ph.D. The procedures used with the study's participants were guided by Celia Fisher, Ph.D. Leah Welty, Ph.D., provided assistance on analytic issues. She is an Associate Professor in the Department of Preventive Medicine and the Department of Psychiatry and Behavioral Sciences and a biostatistician in the Biostatistics Collaboration Center, all at the Feinberg School of Medicine, Northwestern University. The authors also thank Eugene Griffin, Ph.D., for reviewing an earlier version of this article.

The research described in this bulletin was supported under grant numbers 1999–JE–FX–1001, 2005–JL–FX–0288, and 2008–JF–FX–0068 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice.

Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.

Share With Your Colleagues

Please direct comments and/or questions to:

National Criminal Justice Reference Service
P.O. Box 6000
Rockville, MD 20849–6000

800–851–3420
301–240–5830 (fax)
E-mail: responsecenter@ncjrs.gov
Web: www.ncjrs.gov

The Office of Juvenile Justice and Delinquency Prevention is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance; the Bureau of Justice Statistics; the National Institute of Justice; the Office for Victims of Crime; and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking.