

Young Offenders in Custody: An International Comparison of Mental Health Services

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Over the last decade interest in the mental health of young offenders has soared. Given evidence that rates of mental disorders are remarkably high in adolescent offenders, countries have initiated efforts to improve the identification and treatment of mental illness in detained youth. Research examining current mental health screening, assessment, and treatment services has focused largely on American sites; however, there is much to be gained from an international perspective. This article discusses international findings regarding the prevalence of mental illness in detained youth, examines the extent to which countries protect incarcerated youths' right to treatment, and compares countries' provision of screening, assessment, and treatment services to youth in custody and the community. Considerable variability is found to exist across countries and despite some advances in practice—particularly in the area of mental health screening—significant gaps remain between best and actual practices. To ensure that young offenders with mental illness receive adequate treatment, local, in-depth reviews of the mental health services provided to young offenders must be conducted across countries. Additionally, policies and procedures for providing services to young offenders with mental illness must be improved, particularly in the areas of custodial and community mental health treatment.

Keywords: incarcerated youth, mental health services, international comparison, youth justice

Over the past 20 years, interest in juvenile offenders' mental health has increased enormously. In the 1980s, there were virtually no studies examining the prevalence of mental illness in young offenders, whereas today several large-scale, methodologically sound investigations have been conducted. Similarly, little was known about the quantity or quality of mental health treatment in youth justice facilities prior to the late 1990s, whereas in the past 10 years several major examinations of the state of mental health services have been undertaken within both North America and Europe (Chitsabesan et al., 2006; Cocozza & Skowrya, 2000). This article provides a brief overview of the historical trajectory of North American youth justice systems' treatment of young offenders. It reviews the current literature examining the prevalence of

mental illness in young offender populations, and highlights some of the methodological challenges that account for variability between studies. Large-scale American prevalence studies are compared to those conducted internationally, followed by a discussion of why youth justice systems should be concerned about mental illness in young offenders. Finally, this article provides a summary and comparison of current international practices in custodial mental health screening, assessment, and treatment, as well as post-custodial community services for young offenders. Current practices are evaluated in the context of empirically-supported best practices in each of these domains, and future recommendations for policy makers and scholars are provided.

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YOUNG OFFENDERS AND MENTAL ILLNESS: A BRIEF HISTORY

In the United States, interest in young offenders' mental health began to grow in the late 1980s when the number of violent offenses committed by youth spiked dramatically

(Grisso, 2004). In response, many states tightened their young offender laws, with the result that many more youths came into contact with the justice system and custody facilities. This trend has largely persisted in the United States (Snyder & Sickmund, 2006), although there are indications that a shift toward incarcerating fewer youth is taking place (e.g., Benekos & Merlo, 2008; Justice Policy Institute, 2009; Lippman, 2010).

Also during the 1980s and 1990s, justice workers began to report that an increasing proportion of youth appeared to have mental health difficulties (Grisso, 2004). Although several possible explanations for this increase exist, it was likely the result of a decline in adequate mental health services; mentally ill youths were being diverted to custody facilities in the absence of proper community-based treatment (Rosado & Shah, 2007). Youth justice systems were ill-equipped to deal with these youths, leading to calls for research and policy changes. Although the number of crimes committed by youth has been decreasing in both Canada and the United States over the past decade (Snyder & Sickmund, 2006; Thomas, 2008), interest in the identification and treatment of mental difficulties in young offenders continues to grow.

Before steps can be taken to meet the needs of young offenders with mental illness, a better understanding of the pervasiveness of the problem is required. Prevalence studies of mental illness in young offender populations have attempted to address this issue.

WHAT IS THE PREVALENCE OF MENTAL ILLNESS IN YOUNG OFFENDERS?

A review of youth psychopathology prevalence studies determined that around 15%–18% of adolescents in the American general population have a mental disorder (Roberts, Attkisson, & Rosenblatt, 1998). Some prevalence studies estimate relatively similar rates of mental illness—around 25%—in young offender populations (Rohde, Mace, & Seeley, 1997). However, others place the estimate vastly higher at around 85% (e.g., Robertson, Dill, Husain, & Undesser, 2004).

Much of the variability in prevalence rates between studies can be attributed to methodological challenges, including sampling difficulties, measurement issues, and problems related to the definition of ‘mental disorder.’ For example, researchers have variously sampled from sentenced youth (e.g., Steiner, Garcia, & Mathews, 1997), remanded youth (e.g., Gosden, Kramp, Gabrielsen, & Sestoft, 2003), and community-based young offenders (e.g., Garland et al., 2001) to determine the prevalence of mental illness in young offenders. Samples also vary widely in size, from 50 to over 1800 (Pliszka, Sherman, Barrow, & Irick, 2000; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Timmons-Mitchell et al., 1997); smaller samples provide less reliable prevalence rates (Cohen, 1988) and also decrease the likelihood

youth can be compared based on demographic characteristics known to influence prevalence rates, such as gender and ethnicity (Teplin et al., 2006). Finally, many studies do not sample randomly from their population, instead relying on samples of convenience or on youth already identified as having mental health needs (e.g., Neighbors, Kempton, & Forehand, 1992).

Variability between studies is also a result of measurement inconsistency. For example, studies variously use semi-structured interviews (e.g., Teplin et al., 2002), self-report questionnaires (e.g., Bickel & Campbell, 2002), data from court or psychiatric records (e.g., Kramp, Israelson, Mortensen, & Aarkrog, 1987; Rawal, Romansky, Jenuwine, & Lyons, 2004), or other diagnostic methods to determine which youth are mentally ill. Further, while some studies use empirically validated, well-standardized instruments like the Diagnostic Interview for Children (DISC 2.3; e.g., Shaffer et al., 1996), others rely on unstandardized measurement tools with less empirical support (e.g., Rohde et al., 1997).

Finally, studies are inconsistent in their definition of mental disorder and in which mental disorders they choose to include in their survey. Some studies require symptoms to impair functioning for a disorder to be diagnosed, whereas others simply require the presence of symptoms (e.g., Cohen et al., 1990) or the presence of general psychiatric distress alone (e.g., Steiner, Cauffman, & Duxbury, 1999). Others only include a diagnosis if symptoms were present in the past six months or year (e.g., Garland et al., 2001), while others report lifetime prevalence rates (e.g., Rohde et al., 1997). Additionally, some studies restrict their focus to one group of disorders, such as anxiety disorders (e.g., Cauffman, Feldman, Waterman, & Steiner, 1998), while others include a much wider breadth of diagnoses (see also Otto, Greenstein, Johnson, & Friedman, 1992, for a review of these issues). This can lead to substantial variability in the prevalence of mental illness; for example, when authors include conduct disorder in their assessment package, overall prevalence rates of mental illness are uniformly higher (e.g., Shufelt & Coccozza, 2006; Teplin et al., 2002).

Sampling difficulties, measurement issues, and problems related to the definition of ‘mental disorder’ can all be dealt with to a degree by designing methodologically-sound studies that use well-validated instruments to assess a wide range of mental illnesses in large, random samples of young offenders. Several such large-scale studies have been undertaken in the United States, with results indicating extremely high overall prevalence rates as well as important demographic differences. For example, Teplin et al. (2002) found that 66% of males and 74% of females in custody had at least one mental disorder, with females being more likely to be diagnosed with a disorder than males. The finding that justice system-involved females have higher rates of mental illness than their male counterparts has been replicated in several other large-scale studies (Shufelt & Coccozza, 2006; Wasserman, McReynolds, Ko, Katz, & Carpenter, 2005), and has

been largely attributed to their higher rates of internalizing disorders and their greater likelihood of having a history of trauma (Shufelt & Coccozza, 2006).

In terms of ethnic differences, Teplin et al. (2002) found that white males were more likely to be diagnosed with a mental disorder than Hispanic or African American males. Similarly, white females were more likely to be diagnosed with a mental disorder than African American females, and were more likely to be diagnosed with any disorder than Hispanic females when conduct disorder was excluded from analyses. They additionally found differences by age, whereby the youngest males (age 13 and below) had the lowest rates of many of the disorders studied, while rates of mental illness in females tended to vary less by age. Exceptions included that older females were least likely to have oppositional defiant disorder, and that the youngest (age 13 or below) females were least likely to have a substance use disorder.

Finally, prevalence studies have overwhelmingly demonstrated that diagnostic comorbidity is the norm among youth in detention. Abram, Teplin, McClelland, and Dulcan (2003) found that 57% of females and 46% of males in custody had comorbid diagnoses, while Shufelt and Coccozza's (2006) study produced even more striking numbers, with 79% of youth meeting criteria for two or more disorders.

While methodologically-sound prevalence studies of mental illness in juvenile offenders outside of the United States are much less common, a recent meta-analysis that utilized a meta-regression model concluded that there was sufficient convergent international evidence to conclude that: 1) the prevalence of psychosis in juvenile detainees is 10 times general population rates, and 2) female juvenile detainees are more likely to suffer from major depression than boys (Fazel, Doll, & Långström, 2008). Extant international studies, including their sample types and sizes, measurement tools, and primary findings, are summarized in Table 1. Although considerable variability in the prevalence rates of specific disorders exists across studies, overall they suggest that young offenders in many countries display elevated rates of mental illness.

In addition to the methodological issues outlined above, researchers attempting to estimate prevalence rates face a larger problem: how to conceptualize disorders of childhood and adolescence. With each incarnation of the *Diagnostic and Statistical Manual of Mental Disorders (DSM*; American Psychiatric Association) and the *International Classification of Diseases (ICD*; World Health Organization) have come substantial alterations in the definitions of disorders of childhood and adolescence, reflecting the difficulty of determining appropriate diagnostic categories and criteria (Achenbach, 2005; Thomson & Van Loon, 2004). Concerns about the suitability of the current categorical diagnostic systems have led many researchers to consider whether dimensional classification systems are more appropriate (Vincent, Grisso, & Terry,

2008). Indeed, the website for the *DSM-V* currently states that "dimensional assessments are being proposed for inclusion with existing categorical diagnoses in DSM-5 to provide a basis for measurement-based care" (www.dsm5.org), suggesting that a mixed categorical-dimensional system may be in the *DSM's* future.

At present, the mental health classification systems set forth by the *DSM-IV-TR* (American Psychiatric Association, 2000) and *ICD-10* (World Health Organization, 1992) produce high levels of diagnostic comorbidity as well as substantial within-category heterogeneity. Further, diagnoses demonstrate considerable developmental instability and virtually all children will show signs of psychopathology, as defined by the *DSM-IV-TR* or *ICD-10*, at some point during their development (Caron & Rutter, 1992; Kupfer, First, & Regier, 2002; Vincent et al., 2008). This makes the identification of serious as opposed to transient psychopathology difficult. Further, the fact that symptoms may vary in their expression across development—for example, anxiety difficulties in young children are often expressed as depressive problems later in development (Achenbach, 2005)—makes accurate and reliable diagnosis challenging. In attempting to understand the prevalence and nature of psychopathology in children and adolescents, it is important to keep some of the conceptual challenges inherent in this process in mind.

WHY SHOULD THE YOUTH JUSTICE SYSTEM BE CONCERNED ABOUT YOUTHS' MENTAL ILLNESSES?

While the problems noted above make it difficult to assess the true rate of mental health problems in young offenders, there is general agreement that a substantial proportion of these youth have mental health difficulties. There are two principal reasons why the youth justice system should strive to identify youth with mental health concerns: 1) young offenders have a right to receive treatment and 2) mental illness is sometimes linked to delinquent behavior (Grisso, 2004). Although mental illness can also compromise youths' competency, it is rare for youth to present with the type of serious mental illness that would impair their thinking abilities to the extent that they would be declared incompetent; as such, the relationship between mental illness and competency is more relevant to adults (for further information, see Goldstein & Goldstein, 2010; Kruh & Grisso, 2008). Further, issues around competence would be a concern pre-adjudication, and would be less relevant for youth in custody.

Right to Treatment

Do young offenders in custody have a right to receive treatment? This is a seemingly simple question with a very complicated answer. In the United States, states vary in the degree to which they require or allow young offenders to be provided with comprehensive mental health treatment. Lawmakers in

TABLE 1
Studies of Psychiatric Disorders in Juvenile Delinquents Conducted Outside of the United States

Author(s)/Year	Location	Sample	Measures	Major Findings*
Richards, 1996	Australia	Participants: Juvenile detainees referred for a psychiatric evaluation N: 100 Age: 12–20 Gender: 80% male; 20% female Race/Ethnicity: Not reported	Unspecified “semi-structured diagnostic interview”	Conduct disorder: 71% Substance abuse: 73% Affective disorder: 25% BPD: 5% Schizophrenia: 4% ASPD: 4% ADHD: 4% PTSD: 4% Comorbidity: 86% met criteria for 2 or more disorders
Dixon, Howie, & Starling, 2004	Australia	Participants: Juvenile delinquents in custody N: 100 Age: 13.5–19 Gender: Female Race/Ethnicity: Aboriginal: 48%; White: 33%; Asian: 6%; Polynesian/Maori: 12%; Other: 1%	Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL)	Conduct disorder: 91% Substance abuse disorders: 85% Depression: 55% PTSD: 37% Comorbidity: 78% met criteria for 3 or more disorders
Ulzen & Hamilton, 1998	Canada	Participants: Juvenile delinquents in custody N: 49 Age: 13–17 Gender: 78% male; 22% female Race/Ethnicity: Not Reported	Diagnostic Interview for Children and Adolescents-Revised (DICA-R)	ODD Alcohol dependence Conduct disorder Depression SAD ADHD Mania Dysthymia PTSD Any mental disorder: 69% Substance use disorder: 41% Schizophrenia: 2% Schizotypal disorder: 2% Mild depressive episode: 2% Specific phobia: 4% Obsessive-compulsive disorder: 1% Bulimia: 1% Conduct disorder: 31%
Gosden, Kramp, & Gabrielsen, Sestoft, 2003	Denmark	Participants: Juvenile delinquents remanded to custody N: 100 Age: 15–17 Gender: Male Race/Ethnicity: Danish: 50%; Non-Danish: 50%	Schedules for Clinical Assessment in Neuropsychiatry (SCAN) Kiddie – Schedule for Affective Disorders and Schizophrenia for School Aged Children – Present and Lifetime Version (K-SADS-PL) Structured Clinical Interview for DSM-IV (SCID-II)	Male 39.5% 31.5% 31.5% 18.4% 23.7% 28.9% 28.9% 21.1% 15.8% Female 63.6% 63.6% 18.2% 72.7% 54.5% 18.2% 18.2% 45.5% 54.5%
Lader, Singleton, & Meltzer, 2000	England and Wales	Participants: Juvenile delinquents in custody N: 590 Age: 16–20 Gender: 82% male; 18% female Race/ethnicity: White: 78.3%; Black: 14.6%; Other minority: 7.1%	Structured Clinical Interview for DSM-IV (SCID-II) Structured Clinical Assessment in Neuropsychiatry (SCAN)	Male 84–88% 76–81% 22–26% 8–10% Personality (any) ASPD Paranoid Psychosis

TABLE 1
Studies of Psychiatric Disorders in Juvenile Delinquents Conducted Outside of the United States (Continued)

Author(s)/Year	Location	Sample	Measures	Major Findings*
Oliván Gonzalvo, 2002	Spain	Participants: Adjudicated juvenile delinquents in custody N: 35 Age: 14–27 Gender: Female Race/Ethnicity: Unknown	Unknown	Drug/Alcohol abuse: 63%
Bickel & Campbell, 2002	Tasmania	Participants: Juvenile delinquents in custody N: 50 Age: 12–18 Gender: 86% male; 14% female Race/Ethnicity: Aboriginal: 27%	Adolescent Psychopathology Scale (ASP)	Conduct disorder: 98% ADHD: 46% Major depressive disorder: 30% Dysthymia: 16% Anxiety disorder excluding PTSD: 32% PTSD: 36% Adjustment disorder: 22% Somatization disorder: 22%

Note. * ADHD: attention-deficit hyperactivity disorder; ASPD: Antisocial personality disorder; BPD: borderline personality disorder; ODD: oppositional defiant disorder; PTSD: post-traumatic stress disorder; SAD: separation anxiety disorder.

some states have decided that justice facilities have an obligation to provide mental health treatment, and have written this obligation into state law. For instance, Connecticut requires that juvenile delinquents' mental health needs are met (Connecticut Public Act No. 01-181, 2001), as does Florida (Mulford, Reppucci, Mulvey, Woolard, & Portwood, 2004). Other state-level courts have determined that youth justice systems have a responsibility to provide mental health treatment based on federal law. In Indiana and Ohio, courts determined that denying youth mental health services would be a violation of the American Constitution (Mulford et al., 2004). For instance, in *Miletic v. Natalucci-Persichetti* (1992) Ohio courts found that a youth with mental illness in custody has the right to "minimally adequate care and treatment to ensure [their] safety and freedom from undue restraint under the Fourteenth Amendment" (p. 1).

Finally, some states have acknowledged youths' right to receive services indirectly by developing juvenile mental health courts that provide specialized adjudication and treatment services to youth with mental health concerns; at present, there are at least 11 juvenile mental health courts in operation in the United States (Cocozza & Shufelt, 2006).

At the federal level, the Juvenile Justice and Delinquency Prevention Act states that, in order for states to receive grants under this act, they must have "programs designed to provide mental health services for incarcerated juveniles suspected to be in need of such services" (42 U.S.C. §5633 [Sec. 223.]). However, the degree to which this stipulation has spurred improvements in the mental health assessment and treatment of juveniles in custody is unclear. Further, federal courts have determined that individuals in correctional facilities have the right to treatment under the Eight and Fourteenth Amendments of the American Constitution (e.g., *Bowring v. Godwin*, 1977; *Estelle v. Gamble*, 1976; *Madrid v. Gomez*, 1995; *Ruiz v. Estelle*, 1980); the former Amendment bars cruel and unusual punishment and the latter entitles due process rights to all citizens, including youth in custody.

Finally, federal legislation provides that if any U.S. facility or institution fails to supply youth with appropriate mental health services to such an extent that youth are viewed as having been deprived of the "rights, privileges, or immunities secured or protected by the Constitution or laws of the United States," and if this deprivation causes "grievous harm," the Attorney General may take civil action against that institution (CRIPA; 42 U.S.C., §1997a et seq).

In Canada, the declared intention of the Youth Criminal Justice Act (YCJA; 2002, c.1) is to "(i) prevent crime by addressing the circumstances underlying a young person's offending behavior, (ii) rehabilitate young persons who commit offences and reintegrate them into society" (section 3(a), p. 6) and to ensure that young offenders suffer consequences for their actions, all to protect the public. The goals of rehabilitation and crime prevention both indicate the need for mental health treatment, particularly given that mental illness can underlie offending behavior. The YCJA also recognizes

that some youth are in particular need of services and allows judges to order an intensive rehabilitative custody and supervision order for those youth who "(b) . . . [suffer] from a mental illness or disorder, a psychological disorder or an emotional disturbance" and for whom "(c) . . . there are reasonable grounds to believe that the plan might reduce the risk of the young person repeating the offence or committing a serious violent offence" (section 7, p. 48). However, the YCJA goes on to state that such an order shall only be made when the youth has committed a serious violent crime and when appropriate services are available. Research suggests that these orders are rarely, if ever, made (Doob & Sprott, 2005). While the YCJA clearly intends for young offenders to be rehabilitated, its mandate is vague; there is no strict requirement regarding the provision of mental health services.

The Canadian Human Rights Act (1985) may also have some applicability to young offenders' mental health treatment in that denying a young offender services on the basis of their in-custody status could be considered an act of discrimination. However, to date this act has not been used in court to augment arguments for improved custodial mental health services.

Outside of North America, nations vary in the degree to which they endow young people in custody with the right to mental health services. For instance, in Britain, the 2000s have been a period of "increasing emphasis on mental health screening, and providing interventions to reduce offending" (Harrington et al., 2005, p. 4). This emphasis on improving mental health services for young offenders began in the late 1990s when legal recognition of the need to provide appropriate services to young offenders was evidenced in two major legislative documents: the Crime and Disorder Act (1998) and the Youth Justice and Criminal Evidence Act (1999). These documents emphasized the need to divert young offenders away from a criminal lifestyle in a preventative and proactive manner. In 2010, the British Youth Justice Board published the revised National Standards for Youth Justice Services and laid out how such diversions should be accomplished, stating in concrete terms that the youth justice system must ensure that "all children and young people entering the youth justice system benefit from a structured needs assessment to identify risk and protective factors associated with offending behaviour to inform effective intervention" (p. 5).

In contrast, another Commonwealth country, Australia, appears to have established few provisions for the treatment of mental health issues among its juvenile offender population. For example, the Children (Detention Centres) Act of New South Wales (1987) asserts that juvenile justice facilities must "maintain the physical, psychological, and emotional well-being of detainees" but gives no specific direction as to how this should be accomplished (No. 57; Div 2, 14.1.a). Similarly, Queensland's Juvenile Justice Act (1992) states vaguely that juvenile justice facilities must "provide services that promote the health and wellbeing of children detained at the centre" (Part 8, 263.3.a), while South Australia's Young

Offenders Act (1993) makes no mention of mental health, assessment, or treatment whatsoever. The remainder of Australian provinces' young offender acts follow in these same veins, providing little guidance or incentive for custody facilities to provide mental health services to young offenders.

In the Netherlands, a new piece of youth justice legislation came into force in 2001 titled the Youth Custodial Institutions Act (YCIA). The stated intention of this act is to strengthen and protect the legal rights of youth in custody (Bruning, Liefwaard, & Volf, 2004). It states that a treatment care plan, which may include mental health care, must be developed for all youth remaining in justice facilities for three months or more (van Kalmthout & Bahtiyar, 2010). However, a recent review of the implementation of the YCIA notes that the term 'treatment plan' is inconsistently interpreted across institutions and that little information is currently available as to how this new legislation has impacted the treatment of youth in justice facilities (Bruning et al., 2004).

In sum, while some American states appear to acknowledge society's responsibility to provide young offenders with mental health treatment, the nature of this responsibility differs across American states and is often vaguely codified. Other nations vary in the degree to which they provide mental health services. For instance, British authorities appear to be actively working toward improving their nation's system of identification and treatment of mental illness in juvenile offender populations. In contrast, Australia and Canada have few provisions in place to ensure that the mental health needs of young offenders are met, and the degree to which relatively new Dutch legislation is leading to improved mental health services for youth is unclear.

Mental Illness and Delinquency

As noted above, Canada, Britain, Australia and some American states identify addressing the circumstances underlying criminal behavior as one of the goals of the youth justice system. In defining standards for juvenile justice systems, the Commission for Human Rights (2009) in Europe similarly concluded that "a juvenile justice policy that does not include measures aimed at preventing offending is considered deficient" and went on to note that "prevention is often considered the weakest link in the chain of actions intended to promote progressive approaches to juvenile justice" (p. 6). If mental illness is understood as a factor potentially underlying offending behavior, then this emphasis on prevention points to a need for mental health assessment and treatment in juvenile justice facilities. Understanding which mental illnesses are related to delinquency would also allow the youth justice system to be better equipped to rehabilitate young offenders, reducing the likelihood of recidivism and fulfilling its mandate to protect the public.

Studies have begun to clarify the links between offending and mental illnesses. For example, one of the most frequent diagnoses given to young offenders in the United States is, not

surprisingly, conduct disorder (Scott, 1999). However, given that the primary diagnostic criteria for this disorder relate to delinquent behavior, a diagnosis of conduct disorder does not greatly inform our understanding of the roots or factors underlying offending, nor does it provide any direction for interventions.

A diagnosis that is strongly related to future offending in American youth is attention-deficit hyperactivity disorder (ADHD) (Barkley, 1996). Around half of youths with ADHD will eventually come into contact with the youth justice system (Moffit & Silva, 1988); half will eventually also receive a diagnosis of conduct disorder (Jensen et al., 2001; Newcorn et al., 2001) and around a fifth will be diagnosed with antisocial personality disorder in adulthood (Mannuzza, Klein, Bessler, Malloy, & LaPadula, 1993). The relationship between ADHD and offending is rooted both in the hyperactivity and impulsivity that characterize many youth with the disorder as well as the social and educational difficulties they face. Children and adolescents with ADHD typically struggle to adapt to structured school settings and also face challenges interacting with peers; as such, these youth often look to delinquent peer groups for a sense of belonging (Grisso, 1999).

Many youth in the justice system have been exposed to physical, emotional, or sexual trauma; as a result, an elevated proportion of young offenders in the United States meet diagnostic criteria for post-traumatic stress disorder (Cauffman et al., 1998; Steiner et al., 1997). This is particularly true of females (Cauffman et al., 1998), who are twice as likely to have a history of physical abuse and four times more likely to have a history of sexual abuse than males (Sedlak & McPherson, 2010). Trauma is related to a variety of negative outcomes for youth, including poorer mental health generally and an increased likelihood of experiencing depression and suicidality (Chapman et al., 2004; Dube et al., 2001; Veysey, 2008). These youth are also more likely to engage in risky sexual behaviors, abuse substances, and engage in aggressive, violent, and antisocial behaviors (White & Widom, 2003).

Substance use disorders are also extremely common in American young offender populations. Many youths commit crimes while under the disinhibiting influence of drugs or alcohol, and some substances (e.g., LSD, PCP, and stimulants) lead to higher levels of aggression and violence in youth (D'Amico, Edelen, Miles, & Morral, 2008). The presence of a substance use disorder also increases the already high likelihood of having a comorbid disorder. Among juvenile detainees, Teplin et al. (2006) found that 20% of males and 30% of females diagnosed with a substance use disorder also had a comorbid major mental disorder, most commonly ADHD but also frequently an anxiety or affective disorder. These high levels of comorbidity may have important treatment implications; for instance, in a study of 419 U.S. adolescents aged 12–18 years, Sterling and Weisner (2005) found that treating substance abuse alone was often not effective due to the high prevalence of co-occurring disorders.

The relationship between mood disorders like depression and dysthymia and offending is less clear. While most studies find a positive, concurrent correlation between depression and antisocial behaviour in youth (Dixon, Howie, & Starling, 2004; Ritakallio et al. 2007; Vieno, Kiesner, Pastore, & Santinello, 2008), results are not entirely consistent (e.g., Sigfusdottir, Farkas, & Silver, 2004). Further, while several longitudinal studies have shown that depressive symptoms predict later antisocial behavior (Beyers & Loeber, 2003; Capaldi, 1992; Loeber, Russo, Stouthamer-Loeber, & Lahey, 1994), another has suggested that this relationship only exists for girls and that depressive symptoms are protective against offending behavior in boys (Ritakallio et al., 2007).

Given the wide range of mental illnesses that are linked to delinquency and the high prevalence of mental illness in young offender populations, it would be in the justice system's best interests to identify youth with mental illness. By identifying and treating mental illnesses thought to contribute to delinquent behavior, the justice system can work to decrease recidivism and protect public safety. Indeed, in a recent review of institutional intervention programs, Greenwood and Turner (2009) concluded that programs "that support mental health issues are more successful than those that focus on punishment" (p. 372), suggesting that targeting mental illness in youth can successfully reduce the likelihood of reoffending.

At the same time, it is important to note that most youth with mental illness are not violent or delinquent, and that mental illness is likely not the primary determinant of offending behavior—rather, it may increase the likelihood of offending for some youth. One study found that adult criminal behavior could be attributed to childhood mental illness in 20.6% of cases for females and 15.3% of case for males (Copeland, Miller-Johnson, Keeler, Angold, & Costello, 2007). This suggests that while mental illness represents a substantial risk factor for offending, it does not account for the majority of criminal behavior in the population.

IDENTIFICATION AND TREATMENT OF YOUNG OFFENDERS WITH MENTAL ILLNESS: CURRENT AND RECOMMENDED PRACTICES

Given that youth are largely recognized as having the right to receive mental health services while incarcerated and that mental illness may contribute to delinquency, identifying and treating young offenders should be a justice system priority. To provide adequate mental health services, youth justice systems must engage in mental health screening, assessment, and treatment, and ensure the availability of these services both within justice facilities and upon youths' return to their communities.

The following sections review best and current practices in each of these domains. Unfortunately, limited qualitative information is available about mental health services in youth justice facilities outside of the United States. As a result, the following review is incomplete: data from some countries is adequately represented in all of the following sections, while data from other countries is represented in only one or two.

Given that traditional literature search engines produce little information regarding international custodial mental health practices, a variety of alternative information-gathering methods were employed in this review; these included broad internet searches, examinations of official governmental websites and youth justice websites, reviews of documents produced by and for youth justice systems regarding their practices, and direct solicitation of information from internationally-based colleagues.

Mental Health Screening

Recommended practices. Mental health screening is distinct from mental health assessment. Screening is intended to identify youth in a high-risk or crisis state who require emergency intervention, as well as youth who require further assessment. Unless adequate and systematic screening processes are undertaken, a youth's chances of being identified as requiring services and, in turn, of receiving a comprehensive assessment, individualized treatment services, and community re-entry support are limited. Thus, this first step in the mental health service pathway is crucial.

Current guidelines recommend that all youth are screened within 24 hours of contact with the justice system (Cocozza & Skowyra, 2000; Penn, Thomas, & the Work Group on Quality Issues, 2005; Wasserman et al., 2003). This ensures that youth at risk of harming themselves or others, or who are in a mental health crisis, are provided with treatment and support quickly so that harm does not occur. This service is particularly crucial for youth in custody, who show high levels of suicidal behavior. Indeed, 22% of detained youth endorse having attempted suicide in the past—nearly four times the rate in the general population (Sedlak & McPherson, 2010). Screening tools used should be relatively brief, empirically validated, and should not require clinical skills to administer, score, and interpret, lowering the cost of screening (American Academy of Child and Adolescent Psychiatry [AACAP], 2005).

Finally, screening programs may fail to detect problems in newly admitted youth and youth may develop problems when faced with detention facilities' multifarious environmental stressors (Goldstrom, Jaiquan, Henderson, Male, & Manderscheid, 2000). Thus, while mental health screening and assessment upon intake are essential components of an effective institution-based program, it is also important that monitoring of mental health and substance use disorders, emotional and behavioral problems, and suicide risk take place throughout the detention period.

Current practices. In the United States, a recent survey conducted on behalf of the U.S. Office of Juvenile Justice and Delinquency Prevention (Sedlak & McPherson, 2010) found that only 47% of youth justice facilities provided mental health screening for all youth. Further, one-quarter of facilities did not systematically screen all youth for suicide risk and 71% failed to screen all youth within 24 hours, a practice that is crucial given the high prevalence of suicide in this population and the importance of early identification (Sedlak & McPherson, 2010). Most suicide risk assessments were not regularly conducted by trained mental health staff—only 31% of facilities assigned only trained professionals to the task of completing suicide risk assessments. However, this is not problematic so long as facilities adhere to the best-practice recommendation of using screening tools that do not require clinical skills to administer and score.

Thankfully, when selecting tools with which to conduct mental health screenings, it appears that many American sites are opting for empirically validated instruments that meet best practice recommendations. For example, the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2; Grisso & Barnum, 2006; Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001) is currently being used in 41 American states as well as in Australia, Canada, England, Korea, and New Zealand (Grisso, 2005, 2009). This tool is a well-validated, psychometrically sound 52-item self-report survey that does not require special training to administer and takes only 10 to 15 minutes to complete.

In the Netherlands, all youth who engage in serious delinquent behavior are screened to identify those juveniles “whose criminal behavior may be a signal of a more fundamental problem” (Doreleijers & Spaander, 2002, p. 232). This screening procedure is likely adequate, as youth receiving custodial sentences would presumably commit crimes that are considered ‘serious.’ The screening tool used in the Netherlands is the Baris Raads Onderzoek (Basic Protection Board Examination, or BARO) (Doreleijers & Spaander, 2002); its development was prompted by research demonstrating that the tool historically used in the Netherlands had little clinical utility (Doreleijers, Moser, Thijs, van Engeland, & Beyaert, 2000). In response, the government commissioned the BARO, which assesses psychopathology and provides a template for the construction of a final report for each youth (Doreleijers & Spaander, 2002). While this tool does not adhere to all best practice recommendations in that it requires training to administer and is time-consuming to administer and score, it is able to identify psychopathology (Bailey & Tarbuck, 2006) and has gained popularity outside of the Netherlands. Following translation, it is now being used in Scandinavian countries and Germany (Bailey, Doreleijers, & Tarbuck, 2006; Bailey & Tarbuck, 2006).

In Britain, a mental health screening program was launched in 2003 within youth offending teams (YOTs) requiring that a structured general assessment tool (the Asset; Youth Justice Board, 2006) be administered to all justice

system-involved youth (Chitsabeau et al., 2006). If youth are identified by the Asset as potentially having mental health concerns, staff are directed to administer a mental health screening form called the Mental Health Screening Questionnaire Interview for Adolescents (SQIFA; Youth Justice Board, 2003) to elicit further information about whether a comprehensive mental health assessment is required. Although one study found that the SQIFA displayed moderately good sensitivity and specificity (Kroll et al., 1999), another found that it identified only half of the young offenders identified by the Salford Needs Assessment Schedule as having mental health concerns (Harrington et al., 2005). The SQIFA is designed to be amenable to repeated use over time and does not require clinical training to administer (Bailey et al., 2006). Unfortunately, guidelines do not require the SQIFA to be administered when a youth enters a youth custody facility (Harrington et al., 2005)—only when they come into contact with the youth justice system (Chitsabeau et al., 2006), falling short of recommended best practices.

Mental Health Assessment

Recommended practices. Youth positively identified by an initial screening as potentially having mental health difficulties should subsequently receive a comprehensive mental health assessment to determine their mental health needs. The National Commission on Correctional Health Care in the United States recommends that this assessment be conducted within two weeks of a positive screening interview (2004). The results of this assessment should be used to inform custodial or community treatment planning, and assessments should be conducted by an individual with clinical expertise using one or more empirically validated, standardized instruments. Since most evidence-based treatments map onto specific disorders, diagnosis of mental disorders should be included in this assessment to aid in treatment planning (Desai et al., 2006; Wasserman et al., 2003).

Current practices. A survey conducted by Parent et al. (1994) on behalf of the Office of Juvenile Justice and Delinquency Prevention in the U.S. suggested that youth were much more likely to be assessed for drug or alcohol problems than for other types of mental health problems. They found that 75–80% of youth were given a comprehensive substance use assessment, but only 61% were assessed for mental health difficulties. However, this is not necessarily problematic as not all youth require a mental health assessment. More concerning is the manner in which youth were identified as requiring an assessment and how that assessment is conducted. A recent evaluation of justice facilities found that 33% of youth justice facilities used nonsystematic strategies to determine which youth were to be assessed (Evans, Wasserman, Ko, & Katz, 2004). That is, assessments were only provided for those who were subjectively believed to require such an assessment. Forty-eight percent of facilities used the recommended

two-stage process in which youth who were positively identified by the initial screening were referred for assessments.

In terms of the actual assessment methods used, only around a third of facilities in the United States were found to use an empirically validated structured or semi-structured assessment interview; the majority used unstructured interview formats (Evans et al., 2004), which have limited clinical validity. Further, over a third of assessments in youth justice facilities were conducted by staff without specialized mental health training, which compromises the validity and reliability of even well-developed instruments (Desai et al., 2006).

In Canada, an equally subjective system is used to determine which youth are assessed. Section 34 of the YCJA states that judges may order an assessment for any youth charged with a criminal offense, but it does not provide guidance to judges as to which youth to choose. Research suggests that it is more often characteristics of the youth's index offense and the youth's offense history that influence whether an assessment is conducted, rather than the outcomes of a screening tool (Jack & Ogloff, 1997). Further, although the YCJA states that a "qualified person" must conduct the assessment, it does not specify what that individual's qualifications need be.

In Britain, not all youth are assessed upon entry into a custody facility (Harrington et al., 2005)—but once again, this is not necessarily problematic if screening tools have not identified the youth as requiring a comprehensive assessment. Theoretically, YOT teams identify youth requiring further assessment using a 'Screening Pathway.' Youth identified as having possible problems by the SQIFA are then administered The Mental Health Screening Interview for Adolescents by a member of the health staff (Youth Justice Board, n.d.). However, a review of British custody facilities found that YOT screening and assessment reports were frequently missing when youth were transferred to custody, leaving staff with no information regarding youths' mental health needs (Harrington et al., 2005). As a result, required interventions were frequently not delivered because of inadequate assessment of youths' needs.

Mental Health Treatment

Recommended practices. Providing youth with mental health treatment can effectively reduce recidivism (Cuelar, McReynolds, & Wasserman, 2005; Garrido & Morales, 2007; Lipsey, 1995; Sullivan, Veysey, Hamilton, & Grillo, 2007; Teplin et al., 2006), although the factors associated with treatment effectiveness are difficult to identify (Garrido & Morales, 2007). As such, it is vital that youth justice facilities have treatment programs available for offenders and that there is recognition of the unique needs of certain populations. For instance, female offenders tend to have more mental health difficulties, worse outcomes, and a greater need for services than young male offenders (Lewis et al., 1991; Loeber & Stouthamer-Loeber, 1998; Teplin et al., 2006; Zoccolillo, 1992). They are also more likely to display certain

types of mental health difficulties, such as internalizing disorders and trauma-related difficulties (Cauffman et al., 1998). It is important that youth justice systems remain sensitive to the mental health implications of demographic variables when determining which treatment programs to develop for whom.

Best practice recommendations suggest that treatment programming should include multimodal and multidisciplinary care and be based on the outcome of youths' comprehensive assessments. It is recommended that treatment plans are written in a manner that is understandable to justice system workers, contain clear directives that aid implementation, and are individualized based on youths' mental health needs (AACAP, 2005). However, it is important to note that, at this time, we have a limited understanding of the differential effectiveness of intervention programs based on youths' unique characteristics. Cognitively oriented therapies appear to most consistently show positive effects in terms of recidivism (Garrido & Morales, 2007), but there are few studies of the effectiveness of custodial intervention programs that are directed toward ameliorating youths' mental health challenges (AACAP, 2005). Indeed, providing treatment for young offenders' mental health symptoms may be particularly challenging given the high rates of comorbidity in this population (Sterling & Weisner, 2005).

Current practices. While surveys report that approximately 70–80% of youth justice facilities in the U.S. employ some type of mental health professional, around 90% of facilities employ counsellors without mental health training (Goldstrom et al., 2000; Sedlak & McPherson, 2010). One survey found that 77% of youth in custody had informal counselling or support services available to them, 47% had substance use services available, 46% had services available to them if they were suicidal, and 41% had the option of family counselling (Goldstrom et al., 2000). Another found that just over half of youth in custody had met with a counsellor and that around 10% wanted to meet with a counsellor but did not know how (Sedlak & McPherson, 2010).

A more detailed survey that examined mental health service provision in U.S. juvenile justice facilities suggested that of youth diagnosed with a mental illness, only one-quarter received mental health treatment (Shelton, 2005). More severe forms of mental illness (e.g., schizophrenia) were treated less often than milder forms (e.g., tic disorders), and youth who had had repeated contacts with the youth justice system were more likely to receive treatment than those with only one or two contacts (Shelton, 2005). Another study found that only 40% of youth in custody with a diagnosed substance use disorder received treatment, as did 34% of those with mood, anxiety, or disruptive disorders (Novins, Duclos, Martin, Jewett, & Manson, 1999). Some studies have revealed even lower levels of support. Among juveniles in Cook County, Illinois, who required mental health treatment because of a major depressive, manic, or psychotic episode, only 15.4% received treatment in custody (Teplin, Abram,

McClelland, Washburn, & Pikus, 2005). Tennessee courts have been found to refer only 3.2% of youth to formal mental health treatment programs (Breda, 2001), and a study in California found that 6% of youth in custody received mental health interventions (Rogers, Zima, Powell, & Pumariega, 2001).

The inadequacy of mental health services currently provided is even more clearly illuminated by a recent investigation by the United States House of Representatives (2004) that found that two-thirds of youth justice facilities in the U.S. were detaining youth who no longer needed to be incarcerated but who were awaiting mental health services. In 13% of facilities, youth were being held despite not having any charges against them. The report found that youth awaiting services were detained, on average, for an additional six days.

The situation in the Netherlands may bear some similarities. A report by the Committee on the Rights of the Child (1999) noted concerns about delays faced by youth in custody who required mental health treatment. More recently, a report produced on behalf of the Dutch section of the International Commission of Jurists found that long waiting lists for services—often more than a year long—were prolonging the sentences of juvenile offenders, to the extent that some adolescents had successfully sued the Dutch government for damages (van den Berg, Böhre, Graven, Lourijzen, & Mula-begoviæ, 2008). Finally, in Britain, the Youth Justice Board has identified that intervention programs are lacking at custody facilities, and that the currently available resources for distributing interventions are insufficient (Harrington et al., 2005).

Community Services

Recommended practices. The importance of providing community-based services to young offenders cannot be underestimated. In the United States most detained youth spend very little time in custody—usually less than 30 days (Hayes, 2009). In Canada, 43% of youth sentenced to custody are released in less than a month, and 54% of youth remanded to custody are released in less than a week (Calverley, Cotter, & Halla, 2010). Continuity of care between custodial facilities and community organizations is particularly important given that many youth cycle between community living and confinement (Harrington et al., 2005).

Youth should be re-assessed prior to their release from custody to determine their current level of need and ensure that they receive appropriate services upon re-entry into the community (Wasserman et al., 2003). Vulnerable youth who are not supported in their re-entry into society are more likely to return to a delinquent lifestyle and to have their mental health symptoms return to pre-incarceration levels (Kessler, 2002). As such, if continued treatment is required, these placements should be arranged prior to release so that service provision is continuous (AACAP, 2005). Further, if the pre-release assess-

ment suggests that a youth's symptoms or difficulties have remitted, youth should still have access to community services should symptoms recur. This is particularly important because, although youths may show improvements within the structured confines of a justice facility, a return to the community can produce setbacks (Harrington et al., 2005; Kessler, 2002).

Current practices. At present, very few facilities screen or assess youth prior to their release (Evans et al., 2004). Most determinations of community treatment needs are based on the pre-disposition assessment; in some cases the information provided by this assessment is relevant and sufficient. In other cases, particularly those in which a long time period has passed between the pre-disposition assessment and return to the community, a youth's needs may have changed and initial recommendations may no longer apply.

A recent study of serious young offenders in the United States found that around half of participants received some kind of community services for behavioral or emotional problems, although this included programming not directly related to mental health, like job training and educational services (Mulvey, Schubert, & Chung, 2007). Another study examining male delinquents nine years following their release from juvenile detention found that, despite having "well-documented early vulnerabilities and needs," these men "did not obtain the kinds of supports subsequent to juvenile incarceration that might have enabled them to function independently in society" (Lewis, Yeager, Lovely, Stein, & Cobham-Portorreal, 1994, p. 518). More recently, researchers in California noted that young offenders "with medication or treatment needs would often re-offend and be back in custody before any coordinated treatment plan could be developed" (Arredondo et al., 2001). One problem contributing to lack of services may be that, while custody facility staff report having inadequate training and resources to deal with offenders with mental health concerns, community organizations report having inadequate security to deal with mentally ill youth who also offend (Fagan, 1991).

In Britain, community mental health services for young offenders are reported to be inadequate and inconsistent across regions (Kataoka et al., 2001). One review found that, although around half of youth with chronic offense histories received some kind of therapeutic support in their communities, the type and amount of help varied substantially across youth (Hagell & Newburn, 1996). A study by Kurtz, Thornes, and Bailey (1998) found that community workers often had difficulty accessing needed mental health resources for offending youth, with youth often not meeting referral criteria for intervention programs or, when they did, wait-lists being unacceptably long, mental health staff being inadequately trained, and resources being too few.

In some Australian provinces, juvenile detainees experience an amelioration of their mental health symptoms while in custody, but these gains are lost upon re-entry into the community due to inadequate discharge planning (Jarvis, Beale,

& Martin, 2000). Thus, providing youth with continuity of care from detention centers into the community appears to be an area of challenge for many countries.

FUTURE RECOMMENDATIONS: RESEARCH AND POLICY

The following are recommended future practices for both academic researchers and youth justice policy makers; these suggestions are based on the above review of concerns related to young offenders' mental health, and best and current practices for the identification and treatment of mental illness in justice system-involved youth.

Prevalence

Despite recent efforts, methodologically sound studies of the prevalence of mental illness in young offenders are still scarce. Continued efforts in this area are required to confirm general prevalence rates, demographic differences in prevalence rates, and determine how rates differ across countries. For example, there is little knowledge of the prevalence of mental illness in detained youth outside of the United States and virtually no knowledge of how prevalence rates differ by gender, age, or ethnic status in international locations. Similarly, our understanding of the comparative prevalence of mental illness in custodial versus community young offender populations is limited. Although tentative conclusions can be drawn about the prevalence of mental illness generally in young offender populations, variability in prevalence estimates for particular mental illnesses is currently too high to determine the relative prevalence of different disorders, with few exceptions.

In concert with prevalence studies, clinical and developmental psychologists must continue to examine the nature of psychopathology in children and adults. Longitudinal studies examining how mental disorders in children and youth change and evolve over time, and which disorders or patterns of mental illness lead to continued problems in adulthood would provide important information about the developmental trajectory of mental illness in youth. Further, examinations of the appropriateness of categorical, as opposed to dimensional or norm-based, systems of classification are also necessary to determine how current diagnostic systems should be modified.

Right to Treatment

Although there is some acknowledgment of the necessity of providing mental health services to young offenders, the comprehensiveness and breadth of treatment currently provided varies widely across institutions, states, and countries. The necessity of providing mental health treatment to young offenders is not well codified, and the goal of rehabilitating youths is often stated in aspirational terms. Institutions

should have a clear understanding of their responsibilities in terms of the provision of mental health services to young offenders; for this to happen, the right to treatment—including who must be provided with treatment and how comprehensive that treatment must be—should be written into law.

Mental Illness and Delinquency

Although studies have examined the overlap between certain mental disorders and offending behavior, externalizing disorders tend to be emphasized and less focus has been placed on the relationship between offending and internalizing disorders. Further, the nature of the relationship between offending and mental illness remains unclear. Longitudinal studies may be better able to tease apart why some youth with psychopathology become involved in criminal behavior while others do not, and identify the particular core or associated features of mental illness that increase youths' vulnerability to delinquency. Examinations of protective factors may inform these investigations. Knowledge of predictive and causal relationships would allow the development of preventative intervention programs aimed at youth who are at increased risk for becoming violent or delinquent.

Identification and Treatment of Young Offenders with Mental Illness: Current Practices

There is a strong need for in-depth, qualitative descriptions of the mental health services provided within youth justice facilities, particularly outside of the United States. A lack of available information makes it difficult to ascertain what exactly is being done, and limits the ability of justice systems to be informed by practices in other countries. Systematic, in-depth reviews of the methods and standards employed by various countries would also allow more complete international comparisons to be undertaken. This is particularly crucial as methods for managing mental illness within young offender facilities and the community are still in their infancy; as such, it would be ideal for countries to be able to communicate about what has and has not worked within their populations, and collaborate in the development of effective systems.

Mental Health Screening

As noted earlier, a variety of empirically validated, brief mental health screening tools are available to youth justice facilities (e.g., the MAYSI-2). Accessing screening tools that meet best practice recommendations is, as such, no longer a primary challenge for institutions. Instead, the main difficulties custody facilities face relate to the implementation of screening programs that see all youth entering justice facilities being screened within 24 hours of admission. State and federal regulations must support the adoption of such procedures so that they become standard practice across institutions and jurisdictions.

Mental Health Assessment

The link between intake screening and assessment in youth justice facilities must be systematic; youth identified as having potential mental health needs should be provided with a comprehensive mental health assessment conducted by a mental health professional using empirically validated instruments. Although some youth justice systems have recognized the need for specialized mental health staff and the establishment of systematic screening-to-assessment procedures, implementation of these empirically-supported practices appears to be problematic. Once again, the development of policy-level standards and regulations that demand systematic assessment by mental health professionals must be developed and adopted to support these practices in institutions.

Mental Health Treatment

Mental health intervention services for youth in custody are uniformly inadequate across nations. While it is vital that youth who would benefit from mental health services are provided with them, particularly when the youth's disorder is one known to be related to offending behavior, the provision of such services appears to be a major challenge for custody facilities. More research evaluating the effectiveness of custodial intervention programs may help ameliorate this problem, as a lack of consensus as to what constitutes effective mental health programming may be making it more difficult for custody facilities to make good choices about which interventions to supply, and to whom. Understanding how treatments should be matched to youths' needs, for instance, may help to guide custody facilities in determining how their limited intervention resources should be distributed.

Community Services

It is imperative that young offenders are provided with appropriate community mental health services and that these services are matched to their current needs as indicated by a recent assessment. Youth transferring to the community from a custody facility should be provided with continuing care immediately upon their release to prevent a relapse of symptoms. It is also important that researchers continue to investigate what types of community supports and interventions best serve young offenders with mental illness. Many community-based treatment programs for adolescents are simply downward extensions of programs developed for adults (Shelton, 2005); little research has examined whether these programs are truly effective for young offender populations. As is the case for custodial interventions, the provision of adequate community-based mental health services appears to be major area of challenge for youth justice systems.

CONCLUSION

Interest in the mental health of young offenders has been growing over the past 20 years. With increased recognition of the high prevalence of mental illness in this population have come concerns about whether youth justice systems provide adequate services to mentally ill youths and how delinquency and mental illness are related. These concerns have spurred the development of guidelines to help youth justice facilities better identify and treat young offenders with mental illness. Recommendations include screening all youth for emergent risk and mental health needs, assessing those youth suspected of having a mental illness, and providing treatment appropriate to youths' mental health needs. Continuity of care from justice facilities into communities has also been identified as a priority.

Despite many advances, there are still large gaps in our knowledge—particularly regarding current mental health practices in justice facilities outside of the United States—and inadequacies in our youth justice systems. This article attempts to identify those gaps and delineate future directions for researchers and policy makers who are attempting to better understand and manage young offenders' mental illness. With continued research and law and policy amendments, youth justice systems' ability to successfully identify and rehabilitate youth with mental illness has the potential for substantial improvements.

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