Healthy Families and Communities Subcommittee

Meeting the Challenges Faced by Girls in the Juvenile Justice System

2175 Rayburn House H.O.B.

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My name is Linda A. Teplin. I am the Owen L. Coon Professor of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine, Northwestern University. I am also Director of the Psycho-Legal Studies Program, a research group that studies people who "fall between the cracks" of the mental health system into the criminal justice net.

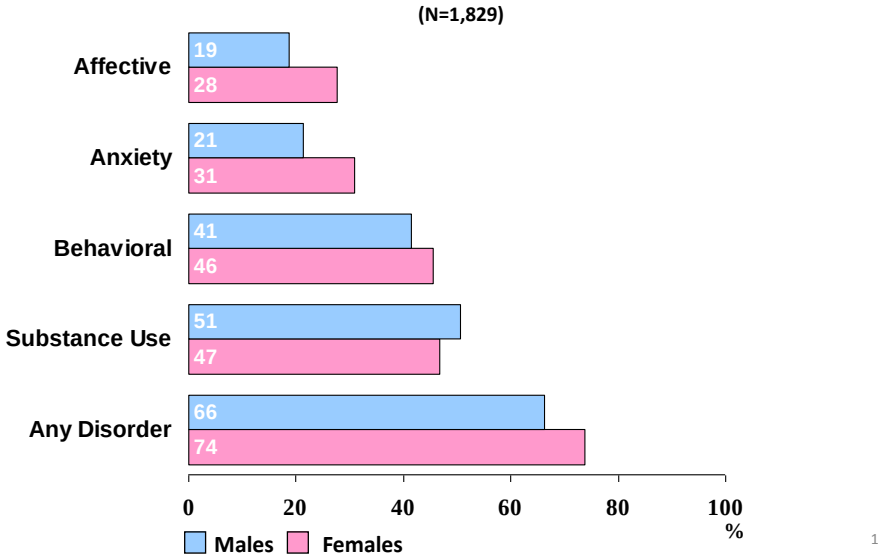
Since 1983, my research group has studied detained populations—adults and juveniles. We are currently conducting the **Northwestern Juvenile Project**, the first large-scale longitudinal study of mental health needs and outcomes of juvenile detainees. We are studying **1829** youth (**657** girls and **1172** boys) randomly sampled as they entered Cook County Juvenile Temporary Detention Center in Chicago, from 1995 to 1998. We chose to study youth in Cook County because Chicago is a typical big city, with typical big-city problems. Since they were enrolled, we continue to track and re-interview our participants. To date, findings have been published in journals that are widely read and broadly distributed: *Pediatrics*, *Archives of General Psychiatry, American Journal of Public Health, Journal of the American Academy of Child and Adolescent Psychiatry, Journal of Consulting and Clinical Psychology,* and *Psychiatric Services*.[1-16]

I am here to present key findings from the Northwestern Juvenile Project, all of which illustrate the dire mental health needs and poor outcomes of juvenile detainees overall, as well as the unique problems of girls. Based on our empirical findings, I will also recommend how the juvenile justice system can address their mental health needs.

I am here to speak about some of the nation's most vulnerable and troubled youth. Without significant investments, this group faces serious risks of school failure, long-term unemployment and reliance on public assistance, continued trouble with the legal system, and premature death. Moreover, making such investments is necessary to promote community safety and to increase the likelihood that these young people will be successful in school, avoid recidivating, and contribute economically.

How common are psychiatric disorders in girls and boys in detention? Our study shows that youth with psychiatric disorders pose a challenge for the juvenile justice system and, after their release, for the larger mental health system. At intake, nearly three-quarters of girls and two-thirds of boys have 1 or more psychiatric disorders, rates 3 to 4 times that of the general population younger than age 18. Girls have significantly higher odds than boys of having any disorder.[1] Substance use disorders are the most common type of disorder, affecting about half of girls and boys (see Figure 1).

Figure 1.
Prevalence of Psychiatric Disorders at the Baseline Interview



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How are the mental health needs of girls different from those of boys? The mental health needs of girls are substantially different than those of boys. For example, girls have significantly higher odds than boys of having affective disorders (such as major depression), any anxiety disorder, and some substance use disorders (using "hard drugs" such as cocaine and amphetamines). Note that these prevalence rates refer to fully developed *disorders*, not merely symptoms of anxiety or use of substances.

What proportion of detained youth has more than 1 disorder? Many juvenile detainees have *more* than 1 disorder, referred to as *comorbid disorders.* Significantly more girls (56.5%) than boys (45.9%) have comorbid disorders. Significantly more girls (22.5%) than boys (17.2%) also have 3 or more types of disorders. In addition, more than one-fifth of girls have 2 or more substance use disorders—most often alcohol and marijuana use disorders. Among girls with an alcohol use disorder, 4 out of 5 also have 1 or more drug use disorder.[6]

I highlight these facts because youth with comorbid disorders are far more difficult to treat and have much poorer outcomes than youth with only 1 disorder. In short, girls are not only more likely than boys to have psychiatric disorders but also more likely to have more complex and intractable problems.

Adverse life events are a fact of life for delinquent girls. Nearly 85% of girls report 1 or more traumatic life event, such as having been attacked physically or beaten badly; 15% meet criteria for post-traumatic stress disorder (PTSD) in the past year.[10] Significantly more girls (27.1%) than boys (9.8%) have ever attempted suicide. Nearly one-third of girls report sexual victimization with force, compared with less than 5% of boys.[10] Such traumatic events in childhood are risk factors for poor psychological and social outcomes.

Do youth who *need* services receive them? Despite their obvious need for mental health services, few receive them. Among youth with a major mental disorder, fewer than 40% of girls receive any evaluation or treatment in the detention center. Ironically, fewer girls are treated in

the community (12.4%) than in the detention center. From the youth's point of view, there are substantial barriers to receiving services. For example, more than 40% of girls report they are unsure about how to access help.

How do youth fare when they leave detention? Three years after detention, approximately 1 of every 5 youth have markedly impaired functioning, indicating a ''need for interventions that are more intensive than standard outpatient care would provide.''[17] These youth struggle to occupy age-appropriate social, occupational, and/or interpersonal roles. Among youth with marked global impairment, nearly two-thirds are severely impaired in 3 or more areas of functioning. For example, these youth may have been expelled from school, engaged in serious violations of the law, and had drug addictions. These findings underscore the ongoing costs to youth and society of the failure to provide effective rehabilitation services during detention and after release.

Impairment at follow-up varies by sociodemographic characteristics. Consistent with patterns of mental health needs among detained youth and youth in the general population, females are more likely than males to be impaired in moods and emotion, self-harm, and substance use.

One of our articles, published in *Pediatrics,* analyzed death rates of the 65 (3.8%) youth who died as of March 2004;[4] 95.5% of these youth died from homicide or legal intervention (e.g., killed by police). Among homicides, 93.0% were from gunshot wounds. Mortality among girls is nearly *8 times* that of general population rates; in contrast, mortality among boys is about *4 times* general population rates.[4]

Since that article was published, 35 more youth have died. As of today, March 11, 2010, 100 of our original 1829 participants have died: 22 girls and 78 boys.

Implications for Juvenile Justice Policy: The US Department of Justice estimates that more than 14,000 girls are held in detention centers on an average day.[18] Extrapolating from our findings, we estimate that as many as 10,000 girls in detention have 1 or more psychiatric disorders.

By law, youth with serious mental disorders should receive mental health treatment while incarcerated.[19-21] Federal courts have affirmed that detainees with serious mental disorders have a right to receive needed treatment as part of the state's obligation to provide needed medical care under the U.S. Constitution's Eighth Amendment (barring cruel and unusual punishment) and Fourteenth Amendment (right to substantive due process for youth in the juvenile justice system) (e.g., *Estelle v Gamble*, 1976;[22] *Ruiz v Estelle*, 1980;[23] *Madrid v Gomez*, 1995;[24] *Bowring v Godwin*, 1977[25]). Despite the legal mandate, recent reports issued by the Surgeon General[26] and the President's New Freedom Commission on Mental Health[19,27] suggest that juvenile detainees are a profoundly underserved population.

Advocacy groups, researchers, and public policy experts are concerned that the juvenile justice system has become the only alternative for treatment for many poor and minority youth with psychiatric disorder. Reports from the Government Accountability Office and the U.S. House Committee on Government Reform demonstrate that a portion of those in juvenile detention are not facing any delinquency charges and remain in these settings only as they await community mental health services.[28,29]

Most delinquent youth experience substantial barriers to services. Youth in the juvenile justice system are disproportionately minority, poor, poorly educated, and have few social networks—

all characteristics known to limit the type and scope of mental health services that are provided.[30,31] Girls who are pregnant or are already mothers face additional barriers due to childcare needs. The Surgeon General reports that, compared with non-Hispanic whites, racial and ethnic minorities have less access to mental health services, are less likely to receive needed care, and are more likely to receive poor-quality care.[32] Moreover, poor minority youth rarely have private insurance.[33,34,35,36,37,38] Many are ineligible for Medicaid.[34,36]

Youth with *comorbid* disorders—common among detained youth—are particularly underserved. A recent report to Congress[39] and the Surgeon General's Report[26] on children's mental health highlighted the paucity of mental health services available to youth with comorbidity. Because the fragmented public mental health system has little to offer,[40] youth with comorbidity may "fall between the cracks" into the juvenile justice net.

Despite the fact that youth with mental and behavioral health needs are overrepresented in juvenile justice, these agencies never were intended to serve as the main point of access for mental health or substance abuse services. Moreover, they are hamstrung by shortages in administrative capacity, funding, and staffing and they also lack sufficient staff training. In many, if not most, cases, other child-serving agencies are better suited to address a youth's mental and behavioral health needs.

The President's New Freedom Commission on Mental Health[19] and the Surgeon General[26] stress the need to improve mental health treatment for youth in the juvenile justice system. Yet, without continued leadership from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), services are not likely to improve. Based on our findings, we recommend that the juvenile justice system provide for the mental health needs of detained youth—and for the specific needs of girls—at each point in the juvenile justice system and hope that Congress will give strong consideration to these issues in the reauthorization of the Juvenile Justice and Delinquency Prevention Act.

1. Before detention:

Increase diversion. Whenever possible, youth with major mental health problems should be diverted to treatment programs or facilities instead of being detained. Most detained youth are charged with nonviolent offenses[41] and could be placed in community-based programs. Effective diversion services require a mental health evaluation following arrest or during judicial review. With collaboration from mental health professionals, juvenile courts can detect and refer many youth, avoiding unnecessary detention.

2. At intake:

Improve screening for psychiatric disorders. The most recent national survey of juvenile justice facilities found that more than 70% provided screening for mental health problems,[42] a substantial improvement over the 24% found in 1983.[43] Although there are promising screening tools,[44,45] additional studies are needed to document their validity. Moreover, we need to improve how we detect comorbid disorders, which are more common among girls than boys. Comorbid mental and substance use disorders are particularly difficult to detect because intoxication and withdrawal can mask or exacerbate psychiatric symptoms (and vice versa).[46,47,48] Yet, failure to accurately diagnose complex conditions will lead to ineffective care and clinical deterioration.

We must focus especially on detecting conditions common among girls, such as trauma and PTSD. The Surgeon General's report on children's mental health suggests that emergency medical providers must address the mental health needs of youth who have experienced trauma.[26] Post-traumatic stress disorder is frequently overlooked even in the best psychiatric settings.[49,50] Because PTSD frequently co-occurs with other psychiatric disorders,[51,52] it can be difficult to detect without systematic screening.

3. During detention:

Avoid retraumatizing youth. The conditions of confinement often exacerbate symptoms of mental disorder.[53] Youth with significant mental and emotional disorders can be vulnerable to abuse and exploitation by others while incarcerated and are more prone to experience adverse consequences of confinement.[53] This may help explain the disturbing information that came from a January 2010 Department of Justice report on sexual victimization in juvenile facilities. They reported that an estimated 12% of youth in state juvenile facilities and large non-state facilities reported experiencing 1 or more incidents of sexual victimization by another youth or staff.[54]

Detention centers must also reduce the likelihood that youth will be retraumatized during routine processing. For example, symptoms of PTSD may be exacerbated by such common practices as handcuffs and searches.[55,56] In detention centers, psychiatric crises are often handled by isolating and restraining symptomatic detainees. These practices can trigger or escalate symptoms of PTSD (e.g., severe anxiety, aggression, numbing of emotions).[55,56] Well-trained mental health professionals can help to develop strategies to manage emergencies more humanely, and ultimately more cost-effectively.

Provide gender-specific services. There is a growing awareness that girls need services designed to address their special needs. Our study shows that girls have greater and *different* mental health problems than boys. In addition, compared with delinquent boys, girls have worse family situations[57-59] and are more likely to have been abused or exploited.[60,61,62,63] These are key risk factors for psychiatric disorders. Recognizing delinquent girls' special needs, federal agencies have established programs designed for them.[64,65-69] These must be continued and expanded.

4. After release from detention:

Ensure linkage to community treatment after release. Most juveniles do not remain in detention for long. The responsibility for their care typically falls to the public mental health system on their release. Treatment in detention will not be successful unless detainees are linked to services in the community. So-called "linkage" services are relatively inexpensive because they can often be managed by paraprofessionals, and the service has tremendous potential to interrupt the criminalization of mentally ill girls and boys. Simply ensuring that a first appointment is made and kept maximizes the chance of successful linkage to services.[70]

Improve services for victims of trauma. Exposure to trauma is a serious public health problem among high-risk youth. Yet, services are insufficient.[71] Timely interventions may avert subsequent and often chronic social problems common among traumatized youth.[72,52,73] To the extent that PTSD is correlated with subsequent violent perpetration, effective treatment is also a matter of public safety.[74,75,76] I greatly appreciate the intent of the OJJDP to focus more on this area of critical need.

Two final notes: First, providing effective screening, evaluation, planning, diversion, and treatment for detained youth in need will not be easy. OJJDP could enhance state and local efforts by providing more extensive training and technical assistance to the many stakeholders. Second, we strongly encourage OJJDP to continue supporting research studies that provide the empirical basis for changes in juvenile justice policy.

Conclusion

The Surgeon General reports that, despite their need for mental health treatment, insufficient services are available for delinquent youth in detention centers and after they return to their communities.[26] To reduce delinquency, improve community safety, and, indeed, the nation's public health, we must redress this omission. For example, treating youth who have behavioral or substance use disorders may reduce their risk of victimization by curtailing the high-risk lifestyles associated with these disorders.[77] Treating youth who have substance use or mood disorders may decrease suicidal risk.[78] Improving mental health services can reduce recidivism.[79] These investments will benefit individuals and communities and provide substantial returns on public expenditures.

Girls have unique mental health needs. They arrive in detention particularly vulnerable, with histories of abuse and exploitation, school failure, multiple home transitions, and childcare needs. Although studies document the high rates of PTSD and depression among girls in detention, mental health screening and treatment are often unavailable or of poor quality; overcrowding worsens an already bad situation. Yet, because girls are underrepresented in the justice system, they often have no access to services that address their special needs.

The challenge to the public health system is to provide accessible, innovative, and effective treatments to a population that is often beyond the reach of traditional services. The challenge to the federal government is to continue supporting efforts and innovation in more and meaningful ways at the state and local levels that provide the right incentives, guidance, and technical assistance. The challenge to us all is in protecting the needs and safety of our young people *and* our communities.

Thank you for your time today. I greatly appreciate the opportunity to discuss and work with the Committee on these critically important issues.

References

1. Teplin LA, Abram KM, McClelland GM, Dulcan MK, Mericle AA. Psychiatric disorders in youth in juvenile detention. *Arch Gen Psychiatry.* 2002;59:1133-1143.
2. Teplin LA, Abram KM, McClelland GM, Washburn JJ, Pikus AK. Detecting mental disorder in juvenile detainees: who receives services. *Am J Public Health.* 2005;95:1773-1780.
3. Teplin LA, Elkington KS, McClelland GM, Mericle AA, Washburn JJ. Major mental disorders, substance use disorders, comorbidity, and HIV-AIDS risk behaviors in juvenile detainees. *Psychiatr Serv.* 2005;56:823-828.
4. Teplin LA, McClelland GM, Abram KM, Mileusnic D. Early violent death among delinquent youth: a prospective longitudinal study. *Pediatrics.* 2005;115:1586-1593.
5. Teplin LA, Mericle AA, Abram KM, McClelland GM. HIV and AIDS risk behaviors in juvenile detainees: implications for public health policy. *Am J Public Health.* 2003;93:906-912.
6. McClelland GM, Elkington KS, Teplin LA, Abram KM. Multiple substance use disorders in juvenile detainees. *J Am Acad Child Adolesc Psychiatry.* 2004;43:1215-1224.
7. Washburn JJ, Romero EG, Welty LJ, et al. Development of antisocial personality disorder in detained youth: the predictive value of mental disorders. *J Consult Clin Psychol.* 2007;75:221-231.
8. Abram KM, Choe JY, Washburn JJ, Teplin LA, King DC, Dulcan MK. Suicidal ideation and behaviors among youths in juvenile detention. *J Am Acad Child Adolesc Psychiatry.* 2008;47:291-300.
9. Abram KM, Paskar LD, Washburn JJ, Teplin LA. Perceived barriers to mental health services among youths in detention. *J Am Acad Child Adolesc Psychiatry.* 2008;47:301-308.
10. Abram KM, Teplin LA, Charles DR, Longworth SL, McClelland GM, Dulcan MK. Posttraumatic stress disorder and trauma in youth in juvenile detention. *Arch Gen Psychiatry.* 2004;661:403-410.
11. Abram KM, Teplin LA, McClelland GM, Dulcan MK. Comorbid psychiatric disorders in youth in juvenile detention. *Arch Gen Psychiatry.* 2003;60:1097-1108.
12. Abram KM, Washburn JJ, Teplin LA, Emanuel KM, Romero EG, McClelland GM. Posttraumatic stress disorder and psychiatric comorbidity among detained youths. *Psychiatr Serv.* 2007:1311-1316.
13. Romero EG, Teplin LA, McClelland GM, Abram KM, Welty LJ, Washburn JJ. A longitudinal study of the prevalence, development, and persistence of HIV/sexually transmitted infection risk behaviors in delinquent youth: implications for health care in the community. *Pediatrics.* 2007;119:e1126-e1141.
14. Elkington KS, Teplin LA, Mericle AA, Welty LJ, Romero EG, Abram KM. HIV/sexually transmitted infection risk behaviors in delinquent youth with psychiatric disorders: A longitudinal study. *J Am Acad Child Adolesc Psychiatry.* 2008;47:901-911.
15. Swahn MH, Whitaker DJ, Pippen CB, et al. Concordance Between Self-Reported Maltreatment and Court Records of Abuse or Neglect Among High-Risk Youths. *Am J Public Health.* 2006;96:1849-1853.

16. Washburn JJ, Teplin LA, Voss LS, Simon CD, Abram KM, McClelland GM. Psychiatric disorders among detained youths: a comparison of youths processed in juvenile court and adult criminal court. *Psychiatr Serv.* 2008;59:965-973.

17. Abram KM, Choe JY, Washburn JJ, Romero EG, Teplin LA. Functional impairment in youth three years after detention. *J Adolesc Health.* 2009;44:528-535.

18. Sickmund M, Sladky TJ, Kang W. Census of Juveniles in Residential Placement Databook. Available at: http://www.ojjdp.ncjrs.org/ojstatbb/cjrp/. Accessed February 16, 2009.

19. The President's New Freedom Commission on Mental Health. Subcommittee on Criminal Justice: Background Paper. Available at: http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf. Accessed January 9, 2005.

20. American Association of Correctional Psychology. Standards for psychology services in jails, prisons, correctional facilities, and agencies. *Crim Justice Behav.* 2000;27:433-494.

21. Soler M. Health issues for adolescents in the justice system. *J Adolesc Health.* 2002;31:321-333.

22. Estelle v Gamble, 429 US 97 (1976); 1976.

23. Ruiz v. Estelle, 503 F. Supp. 1265 (SD Tex. 1980); 1980.

24. *Madrid v Gomez*. 889 F. Supp. 1146, 9617277v2. US 9th Circuit Court of Appeals (ND CA 1995); 1995.

25. Bowring v. Godwin, 551 F.2d 44, 47 (4th Circuit 1977); 1977.

26. US Department of Health and Human Services. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: US Government Printing Office; 2000.

27. Hogan MF. New Freedom Commission Report: The President's New Freedom Commission: Recommendations to Transform Mental Health Care in America. *Psychiatr Serv.* 2003;54:1467-1474.

28. Government Accountability Office. Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services. Available at: http://www.gao.gov/new.items/d03397.pdf. Accessed March 9, 2010, 2010.

29. United States Congress. Incarceration of Youth Who are Waiting for Community Mental Health Services in the United States. Available at: http://hsgac.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=bdb90292-b3d5-47d4-9ffc-52dcd6e480da.

30. McKay MM, McCadam K, Gonzales JJ. Addressing the barriers to mental health services for inner city children and their caretakers. *Community Ment Health J.* 1996;32:353-361.

31. Kataoka SH, Zhang L, Wells KB. Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *Am J Psychiatry.* 2002;159:1548-1555.

32. US Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity -- A Supplement to Mental Health: A Report of the Surgeon General*. Washington, DC: US Government Printing Office; 2001.

33. Moffitt RA, Slade EP. Health care coverage for children who are on and off welfare. *The Future of Children.* 1997;7:87-98.

34. Newacheck PW, Hughes DC, Cisternas M. Children and health insurance: an overview of recent trends. *Health Aff (Millwood).* 1995;Spring:245-254.

35. Fronstin P. Children without health insurance: an analysis of the increase of uninsured children between 1992 and 1993. *Inquiry.* 1995;32:353-359.

36. Lieu TA, Newacheck PW, McManus MA. Race, ethnicity, and access to ambulatory care among US adolescents. *Am J Public Health.* 1993;83:960-965.

37. Holl JL, Szilagyi PG, Rodewald LE, Byrd RS, Weitzman ML. Profile of uninsured children in the United States. *Arch Pediatr Adolesc Med.* 1995;149:398-406.

38. Flores G, Fuentes-Afflick E, Barbot O, et al. The health of Latino children: Urgent priorities, unanswered questions, and a research agenda. *JAMA.* 2002;288:82-90.

39. Substance Abuse and Mental Health Services Administration. *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders.* Rockville, MD: US Department of Health and Human Services; 2002.

40. Cohen R, Parmelee DX, Irwin L, et al. Characteristics of children and adolescents in a psychiatric hospital and a corrections facility. *J Am Acad Child Adolesc Psychiatry.* 1990;29:909-913.

41. Sickmund M, Wan Y. *Census of Juveniles in Residential Placement Databook.* Washington,DC: Office of Juvenile Justice and Delinquency Prevention; 2001 2001.

42. Goldstrom I, Jaiquan F, Henderson M, Male A, Manderscheid RW. The availability of mental health services to young people in juvenile justice facilities: a national study. In: Manderscheid RW, Henderson MJ, eds. *Mental Health, United States, 2000*. Rockville: USDHHS, Center for Mental Health Services; 2001:248-268.

43. Anno BJ. The availability of health services for juvenile offenders: Preliminary results of a national survey. *Journal of Prison & Jail Health.* 1984;4:76-90.

44. Wasserman GA, Jensen PS, Ko SJ, et al. Mental health assessments in juvenile justice: report on the Consensus Conference. *J Am Acad Child Adolesc Psychiatry.* 2003;42:751-761.

45. Grisso T. Juvenile offenders and mental illness. *Psychiatry, Psychology and Law.* 1999;6:143-151.

46. King CA, Ghaziuddin N, McGovern L, Brand E, Hill E, Naylor M. Predictors of comorbid alcohol and substance abuse in depressed adolescents. *J Am Acad Child Adolesc Psychiatry.* 1996;35:743-751.

47. Stowell RJA, Estroff TW. Psychiatric disorders in substance-abusing adolescent inpatients: a pilot study. *J Am Acad Child Adolesc Psychiatry.* 1992;31:1036-1040.

48. Greenbaum PE, Foster-Johnson L, Petrila A. Co-occurring addictive and mental disorders among adolescents: prevalence research and future directions. *Am J Orthopsychiatry.* 1996;66:52-60.

49. Cascardi M, Mueser KT, DeGiralomo J, Murrin M. Physical aggression against psychiatric inpatients by family members and partners. *Psychiatr Serv.* 1996;47:531-533.

50. Mueser KT, Goodman LB, Trumbetta SL, et al. Trauma and posttraumatic stress disorder in severe mental illness. *J Consult Clin Psychol.* 1998;66:493-499.

51. Kessler RC, Sonnega A, Bromet J, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry.* 1995;52:1048-1060.

52. Giaconia RM, Reinherz HZ, Silverman AB, Pakiz B, Frost AK, Cohen E. Traumas and posttraumatic stress disorder in a community population of older adolescents. *J Am Acad Child Adolesc Psychiatry.* 1995;34:1369-1380.

53. Coalition for Juvenile Justice. *Handle with Care: Serving the Mental Health Needs of Young Offenders*. Washington, DC; 2001.

54. Bureau of Justice Statistics. Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09. Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/svjfry09.pdf.

55. Prescott L. *Improving policy and practice for adolescent girls with co-occurring disorders in the juvenile justice system.* Delmar, NY: The GAINS Center; 1998 1998.

56. Veysey BM. Specific needs of women diagnosed with mental illnesses in U.S. jails. In: Levin BL, Blanch AK, Jennings A, eds. *Women's mental health services: A public health perspective*. Thousand Oaks, CA: Sage Publications, Inc; 1998:368-389.

57. Chesney-Lind M, Shelden RG. *Girls, Delinquency, and Juvenile Justice*. Pacific Grove, CA: Brooks/Cole; 1992.

58. Henggeler SW, Edwards J, Borduin CM. The family relations of female juvenile delinquents. *J Abnorm Child Psychol.* 1987;15:199-209.

59. Silverthorn P, Frick PJ. Developmental pathways to antisocial behavior: the delayed-onset pathway in girls. *Dev Psychopathol.* 1999;11:101-112.

60. Lewis DO, Yeager CA, Cobham-Portorreal CS, Klein N, et al. A follow-up of female delinquents: maternal contributions to the perpetuation of deviance. *J Am Acad Child Adolesc Psychiatry.* 1991;30:197-201.

61. Chamberlain P, Reid JB. Differences in risk factors and adjustment for male and female delinquents in Treatment Foster Care. *J Child Fam Stud.* 1994;3:23-36.

62. Dembo R, Williams L, Schmeidler J. Gender differences in mental health service needs among youths entering a juvenile detention center. *J Prison Jail Health.* 1993;12:73-101.

63. Viale-Val G, Sylvester C. Female delinquency. In: Sugar M, ed. *Female adolescent development (2nd ed)*. Philadelphia, PA: Brunner/Mazel, Inc; 1993:169-191.

64. Ravoira L. National Girls' Caucus. *Juvenile Justice Journal.* 1999;6:21-28.

65. Daniel MD. The Female Intervention Team. *Juvenile Justice Journal.* 1999;6:14-20.

66. Acoca L. Investing in Girls: A 21st Century Strategy. *Juvenile Justice Journal.* 1999;6:3-13.

67. Budnick KJ, Shields-Fletcher E. *What About Girls?* Washington: Office of Juvenile Justice and Delinquency Prevention; 1998 1998. FS 9884.

68. Greene Peters and Associates. Guiding principles for promising female programming: An inventory of best practices. Available at: http://www.ojjdp.ncjrs.org/pubs/principles/contents.html. Accessed March, 22, 2005.

69. Community Research Associates. Juvenile Female Offenders: A Status of the States Report. Available at: http://ojjdp.ncjrs.org/pubs/gender/contents.html. Accessed March, 22, 2005.

70. Koroloff NM, Elliott DJ, Koren PE, Friesen BJ. Linking low-income families to children's mental health services: an outcome study. *J Emot Behav Disord.* 1996;4:2-11.

71. Costello EJ, Erkanli A, Fairbank JA, Angold A. The prevalence of potentially traumatic events in childhood and adolescence. *J Trauma Stress.* 2002;15:99-112.

72. Davidson JRT, Hughes D, Blazer DG, George LK. Post-traumatic stress disorder in the community: an epidemiological study. *Psychol Med.* 1991;21:713-721.

73. Bell CC, Jenkins EJ. Traumatic stress and children. *J Health Care Poor Underserved.* 1991;2:175-185.

74. Cauffman E, Feldman S, Waterman J, Steiner H. Posttraumatic stress disorder among female juvenile offenders. *J Am Acad Child Adolesc Psychiatry.* 1998;37:1209-1216.

75. Fehon DC, Grilo CM, Lipschitz DS. Correlates of community violence exposure in hospitalized adolescents. *Compr Psychiatry.* 2001;42:283-290.

76. Wekerle C, Wolfe DA, Hawkins DL, Pittman AL, Glickman A, Lovald BE. Childhood maltreatment, posttraumatic stress symptomatology, and adolescent dating violence: considering the value of adolescent perceptions of abuse and a trauma mediational model. *Dev Psychopathol.* 2001;13:847-871.

77. Loeber R, Burke J, Mutchka J, Lahey BB. Gun Carrying and Conduct Disorder: A Highly Combustible Combination? *Arch Pediatr Adolesc Med.* 2004;158:138-145.

78. Shaffer D, Gould MS, Fisher P, et al. Psychiatric diagnosis in child and adolescent suicide. *Arch Gen Psychiatry.* 1996;53:339-348.

79. Foster EM, Qaseem A, Connor T. Can better mental health services reduce the risk of juvenile justice system involvement? *Am J Public Health.* 2004;94:859-865.