ADDRESSING AND RESPONDING TO VIOLENCE RISK IN JUVENILES

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I. Juvenile Violence Statistics

A. Despite heightened focus of the last decade related to juvenile violence, juvenile arrests for violent crimes fell 36% between 2007 and 2012 (Puzzanchera 2014).

B. Juvenile murderers:

1. Juvenile offenders were involved in an estimated 800 murders in the U.S. in 2010-8% of all murders. This represents the lowest number of murders committed by juveniles since at least 1980.

2. The juvenile offender acted alone in 48% of these murders, acted with one or more other juveniles in 9%, and acted with at least one adult offender in 43%.

3. Most victims of juvenile offenders (76%) were killed with a firearm.

II. Mental illness and Juvenile Delinquents

A. The Northwestern Juvenile Project (NJP) was implemented to study a randomly selected sample of 1,829 youth who were arrested and detained in Cook County, Illinois. The NJP is a longitudinal study that investigates the mental health needs and long-term outcomes of youth detained in the juvenile justice system. This investigation also follows youth after they are arrested and detained, unlike many other studies.

B. Key findings from this study include (Teplin et al 2013).

1. Psychiatric disorders are prevalent: 66% of males and 74% of females met the criteria for at least one disorder at the baseline interview in detention. Having multiples disorders was common.

2. Substance use disorders are the most common: 51% of males and 47% of females met diagnostic criteria at baseline. Marijuana is drug of choice.

3. 93% had been exposed to one or more traumas prior to baseline with more males than females reporting exposure to at least one trauma.
4. Three years after the baseline interview, 17% of detained youth had developed ASPD.

III. Assessing Future Dangerousness

A. Assessment of future dangerousness is an assessment of future risk based on the combination of risk factors and social context.

B. In addition to reviewing official records or convictions, take a self-reported history of violence. Self-reports of juvenile violence reveal many more offenses and offenders than do official records.

C. Particular risk factors include:

1. Early age of onset, particularly prior to age 11 (Mulder et al 2011).

2. Unknown victim of prior offenses (Mulder et al 2011).

3. Chronicity. A small proportion (6%) of early male delinquents become chronically antisocial and these delinquents proceed to commit more than 50% of all crimes (Vincent GM 2006).

4. **KEY POINT:** “Diversification” - Number and variety of offenses more likely predictive than the severity of any one single offense. In a study of 168 incarcerated juvenile delinquent males with lengthy histories of criminal and violent behavior, individuals with earlier onset to criminal behavior and greater criminal versatility escalate to more severe violence (Vitacco et al 2007).

5. **Conduct disorder and persisting antisocial traits.** Conduct disorder has been demonstrated to be the diagnosis that is the strongest predictor of juvenile justice involvement.

6. Involvement with weapons, particularly guns.

7. Involvement with gangs. Although gang members represent a minority of the population, they are responsible for the vast majority of delinquent acts to include violent and nonviolent offenses (Snyder and Sickmund 2006).

8. Substance usage. Serious/chronic offenders are much more likely than other juvenile offenders to be substance users and to qualify as having substance use disorders. Substance use and offending at one age is a consistent predictor of continued serious offending at a later age (Mulvey, Schubert and Chassin 2010).

9. Investigating family issues:
a. Criminal behavior in family members (Mulder 2011)

b. Witnessing violence within the family or being victim of child abuse (physical and emotional abuse) (Mulder 2011)

10. Attention Deficit Hyperactivity Disorder

a. A 30-year prospective follow-up study of hyperactive boys noted that hyperactive boys were at an increased risk for antisocial behavior as adults and SES and IQ, and childhood conduct problems were related to antisocial outcome. Hyperactive subjects who did not manifest conduct problems as children did not exceed the control group in rates of adult antisocial behavior (Satterfield et al. 2007). Similar findings were noted in a 30-year follow up study by Mordre et al. (2011).

b. In contrast to the above study, Mannuzza et al (2008) noted that boys (white) ages 6-12 with ADHD who were free of conduct disorder and were assessed at ages 18 and 25, had increased rates of felonies and aggressive offenses. Results suggest that even in the absence of comorbid conduct disorder in childhood, ADHD increases the risk for developing antisocial and substance use disorders in adolescence, which, in turn, increases the risk for criminal behavior in adolescence and adulthood.

c. In their review of 18 prospective studies (n=5,501) and 13 cross-sectional/retrospective studies (n=2,451), Storebo and Simonsen (2013) concluded that there is an increased risk for children with ADHD with or without comorbid CD to develop antisocial personality disorder.

IV. Risk Assessment Approaches

A. The purpose of risk assessment has changed over the last decade from a prediction-oriented model, focused on risk identification, to a need-oriented model, focused on the use implementing risk reduction strategies to identified criminogenic needs (Heilbrun 2009).


1. Risk principle—suggests that the level of services provided should be based on the level of risk for reoffending. Youth classified as “higher risk” should receive more intensive intervention than youth with lower risk levels. An important caveat to the Risk principle, supported by research, is that providing intensive services to lower-risk youth is not only an inefficient use of resources, it may actually increase the likelihood that those youth will reoffend.
2. Need Principle—points to the kinds of needs that programs should address in order to achieve the best results. Criminogenic needs include antisocial/pro-criminal attitudes, pro-criminal associates, or abuse of alcohol and or drugs.

3. Responsivity principle—how the individual reacts to the treatment environment and how programming is delivered.

C. Three general approaches to assessing and managing violence risk (either alone or in combination):

1. Clinical evaluation or professional clinical judgment method. This involves identification of potential risk factors through clinical interview and/or review of collateral information.

2. Actuarial instruments—based on a set of risk factors known to be associated with recidivism; a numerical score determines the final risk estimate. In general, assumes a linear relationship between the numerical score and the final risk estimate. The Youth Level of Service/Case Management Inventory (YLS/CMI) is one example of an actuarial instrument to assess the risk of general recidivism (Hoge and Andrews 2002). Features of the YLS/CMI include:

   a. Based on R-N-R Model
   b. Was originally developed for probation officers to assist them in writing predisposition reports.
   c. Authors indicate, however, that the instrument is appropriate for all decision areas within the juvenile justice system requiring an assessment of the youth’s risk and need levels.
   d. Intended for developing individual treatment plans for use by criminal justice practitioners in developing individual treatment plans and managing juvenile offender populations in various correctional settings.
   e. Contains 42 dichotomous items.
   f. Has eight domains that are reviewed: offense history; family circumstances/parenting, education, peer relations, substance abuse, leisure/recreation, personality/behavior, and attitudes/orientation.
   g. Juveniles that score from 0-8 are classified as low risk; from 9-22 are classified as moderate risk; scores from 23-34 are classified as high risk; and scores from 35-42 are classified as very high risk.
   h. In a study by Catchpole and Gretton (2003), not one of the 21 youths classified at the low and moderate risk levels were found to have violently recidivated, while 30% of the high to very high risk juveniles violently re-offended during the follow-up period of one year.
   i. Bechtel et al (2007) conducted a study of the predictive validity of the YLS/CMI on a sample of Ohio 4,482 youth who received placement back in the community or within an institution. For purposes of this study, recidivism was defined as any type of conviction or commitment post-release from their community or institutionalized sentence. The follow up period was
approximately 3.4 years. Multiple analyses revealed that the instrument demonstrated predictive validity for both groups and may be a stronger predictor for the community-sentenced offenders than that of the institutionalized group.

3. Structured professional judgment tools-designed to guide the clinician to a documented decision on the final risk estimate, the specific intervention needs, and the intensity of intervention. The SPJ approach does not in all cases assume a linear relationship between total score and recidivism but rather takes into account through a specific combination of risk factors and/or a consideration of the risk factors in combination with the context in which the juvenile resides.

V. **Structured Assessment of Violence Risk in Youth (SAVRY)** (Borum et al 2006)

A. The SAVRY is designed to assist professional evaluators in assessing and making judgments about a juvenile’s risk for violence. The SAVRY is based on the Structured Professional Judgment (SPJ) model. The authors recommend this model because:

1. Anchored in the empirical and professional literature.
2. Allows for appropriate consideration of developmental factors.
3. Emphasizes the dynamic, and often contextual, nature of risk.

B. Manual notes that in general, psychologists, psychiatrists, trained juvenile probation officers, and social workers with requisite expertise are qualified to use the SAVRY.

C. The SAVRY is composed of 24 risk items drawn from existing research and professional literature on adolescent development and on violence and aggression in youth. Each risk item has a three-level rating structure with specific rating guidelines (Low/Moderate/High). These 24 risk items are dispersed among three general categories:

1. Historical risk factor-10 specific factors are:
   - History of violence
   - History of nonviolent offending
   - Early initiation of violence
   - Past supervision/intervention failures
   - History of self-harm or suicide attempts
   - Exposure to violence in the home
   - Childhood history of maltreatment
   - Parental/caregiver criminality
   - Early caregiver disruption
   - Poor school achievement

2. Social/contextual risk factors. The six specific factors are:
• Peer delinquency
• Peer rejection
• Stress and poor coping
• Poor parental management
• Lack of personal/social support
• Community disorganization

3. Individual/Clinical risk factors. The eight specific factors are:

• Negative attitudes
• Risk taking/impulsivity
• Substance-use difficulties
• Anger management problems
• Low empathy/remorse
• Attention Deficit/Hyperactivity difficulties
• Poor compliance
• Low interest/commitment to school

D. Six protective factors are also provided and these are rating on a two-level rating structure (Present/Absent). The protective factors are:

• Prosocial involvement
• Strong social support
• Strong attachments and bonds
• Positive attitude toward intervention and authority
• Strong commitment to school
• Resilient personality traits

Example of scoring clinical item titled “negative attitudes”

Joe is a 15-year-old boy who is charged with the attempted murder of a 16-year-old male related to rival gang activity. When asked about his involvement in his gang, he states, “This is the way we deal with things, man…and it works.” He adds, “The gang is my family. If someone messes with my family, I will take them out.” He adds, “I am always on the look out for someone to screw me or my friends over, so I have to get them before they get me. There is no other way to survive.”

According to the manual, a “low rating” means that the youth’s attitudes do not support legitimacy of crime or violence, a “moderate” rating indicates some support for the legitimacy of crime or violence, or a “high” rating indicates that the youth condones violence or views violence as the preferred method to deal with problems.

Based on this limited information, how would you rate Joe on this item? Low, moderate, or high?
VI. **Psychopathy Checklist: Youth Version** (PCL:YV; Forth, Kosson, and Hare 2003)

A. The PCL:YV is a clinical measure to assess juveniles from 12 to 18 years of age for psychopathic traits.

B. It consists of 20 items that are scored on a 3-point scale, resulting in total scores from 0-40.

C. Because psychopathic traits have been found to be associated with criminal recidivism, the PCL:YV is frequently used for risk assessment purposes.

D. Research on psychopathy in juveniles is controversial with opposing views on identifying a juvenile as psychopathic.

   1. Edens et al (2001) argue that it seems impossible to adequately assess psychopathy in juveniles, as they are still developing. In addition, some traits, such as impulsiveness and sensation seeking behaviors, may reflect normative developmental problems. Concern

   2. A large body of research, however, supports a juvenile psychopathy construct. Lynam et al (2009) has shown that psychopathy tends to be rather stable from ages 7 to 17. In addition, the identification of psychopathy early in life is important to avoid the negative consequences that may result.

E. In the meta-analysis of 53 studies involving over 10,000 participants, Asscher et al (2011) investigated whether psychopathy was associated with delinquency and violent recidivism. Key findings:

   1. The researchers concluded that screening for the early detection of psychopathy is important as delinquent behavior and recidivism can be predicted from psychopathy as early as the transition from middle childhood to adolescence.

   2. When the associations between individual psychopathic traits and reoffending were examined, both impulsiveness and callous-unemotional traits were equally strongly associated with delinquency and impulsiveness was somewhat more strongly associated with recidivism.

VII. **Research on risk assessment instruments** (Khanna et al 2014)

A. The use of structured risk assessments have shown to better assess future violence in juveniles’ risk when compared to clinical risk assessment alone.

B. There have been a number of studies that have compared the predictive accuracy of the YLC/CMI, SAVRY, and the SAVRY. The findings suggest:
1. The SAVRY may be a better predictor of offending (violent and general) than the PCL:YV and YLS/CMI.

2. The SAVRY adds incremental accuracy to the PCL:YV and YLC/CMI.

VIII. Violent School Students-Overview

A. Results from a 2013 nationally representative sample of youth in grades 9-12 provide the following information (Understanding School Violence 2015):

1. 8.1% reported being in a physical fight on school property in the 12 months before the survey.

2. Approximately 1 in 5 students reported being bullied on school property during the 12 months prior to the survey.

3. 5.2% reported carrying a weapon (gun, knife, or club) on school property on one or more days in the 30 days before the survey.

B. School associated violent deaths are rare (Robers et al 2014):

1. 11 homicides of school-age youth ages 5 to 18 years occurred at school during the 2010-2011 school year.

2. Of all youth homicides, less than 1% occur at school, and this percentage has been relatively stable for the past decade.

C. Following the 1999 shootings at Columbine High School, both the FBI and Secret Service evaluated if it was possible to develop a “profile” of homicidal students. Characteristics from both of these studies included:

1. Many students felt rejected and victimized by peers, mistreated by teachers, and unloved by parents;

2. Many students spent many hours preoccupied with violence through music, movies, or video games;

3. Many students had personality pathology characteristics such as narcissism, paranoia and being manipulative or feeling alienated combined with depressed feelings.

   However, no set of characteristics with sufficient specificity as many of the characteristics can be found in many students who are not violent.

D. Both the FBI and Secret Service study noted that most of attackers communicated or leaked their intentions prior to their attack. In addition, many of the students spent a great deal of time planning and preparing their attack or issuing warnings to persons they did not want to kill or expressed anger toward those that they did want to kill.
E. Because many students communicate threats of violence, interventions when threats are identified provide an opportunity to prevent an attack. This investigative process is known as a threat assessment. This process does not attempt to match a profile of a student at risk for violence but instead investigates if the student has engaged in behavior suggesting a pattern of behavior leading to a violent act. However, although a student’s threat might be an indicator of a possible attack, some attacks occur without a threat and many threats do not lead to violence.

F. General principles in evaluating threats

1. Not all threats are created equal.

2. A “zero tolerance” policy for all threats does not consider developmental level or context and therefore results in likely overreactions without a beneficial impact on improving school safety.

3. Once a student has been identified in making a threat, the next step is to determine if the student poses a threat.

4. The Secret Service and U.S. Department of Education recommended evaluating threats in a broader context with efforts to address bullying, resolving student conflicts, fostering trust and communication between students and adults and encouraging student to break the code of silence and seek help. This perspective focuses on threat assessments as threat management.

IX. The Virginia Student Threat Assessment Model (Cornell 2011)

A. Researchers at University of Virginia developed a set of guidelines to use in responding to a set of guidelines for school administrators to use in responding to a student threat of violence. Involves a decision tree analysis.

1. Evaluate threat

   • Obtain a specific account of the threat by interviewing the student, the recipient of the threat and other witnesses.
   • Write down exact content of threat and statements by each party.
   • Consider the circumstances in which the threat was made.

2. Decide if threat is clearly transient or substantive

   Transient threats are those that are readily identified as expressions of anger or frustration but dissipate quickly when the student has time to reflect on the meaning of what he or she has said. In this situation, there is not sustained intention to harm someone.
Substantive threats are those that include the following indicators:

- Plausible details
- Threat repeated over time or communicated to multiple people
- Threat involves planning
- Student has accomplices are has attempted to recruit accomplices
- Student has invited to watch the threatened event
- There is physical evidence of intent to carry out the threat

3. Respond to transient threat

- Responses may include reprimand, discipline, and/or parental notification.
- Student may be required to make amends or attend counseling.

4. Decide whether the substantive threat is serious or very serious

5. Respond to serious substantive threat immediately

6. With very serious threat, immediately conduct safety evaluation

7. With very serious threat, immediately implement a safety plan

B. Five published studies provide promising support for the use of the Virginia Student Threat Assessment Guidelines but more research is needed. In particular, there is a need to conduct a randomized controlled study of school using threat assessment versus alternative approaches, to examine changes in school before and after implementation of this program.

X. Universal School-Based Programs for the Prevention of Violent and Aggressive Behavior (Hahn et al 2007)

A. These programs teach all (regardless of risk) students in a school or school grade about the problem of violence and its prevention and provide an array of topics or skills intended to reduce aggressive or violent behavior.

B. During 2004-2006, the Task Force on Community Preventive Services conducted a systematic review of published scientific evidence concerning the effectiveness of these programs. The results of this review provide strong evidence that universal school-based programs decrease rates of violence and aggressive behavior among school-aged children. Program effects were demonstrated at all grade levels.

XI. Risk-Sophistication-Treatment Inventory (RSTI) (Salekin 1998)

A. A semistructured interview and rating scale that is used by clinicians to assess the functioning of juvenile offenders, ages 9-18.
B. 45 items scored as 0, 1, or 2.

C. Interpretation of RSTI scores “requires graduate training in clinical child psychology, adolescent psychology, developmental psychology, as well as relevant training or coursework in the interpretation of psychological tests at an accredited college or university.”

D. Specific goals are:

1. Organize information to provide a clinically useful assessment instrument for juvenile offenders.

2. Provide a measure that can address serious juvenile justice questions, including, but not limited to, providing psychological evaluations for youth being considered for transfer to adult court (or reverse transfer to juvenile court).

E. Three important areas evaluated with 15 items in each area and scoring guidelines for each item. Each of the three key areas rank the juvenile in a low, middle, or high range on that scale based on comparative sample of juvenile delinquents:

1. Risk of dangerousness: assesses the history of violent and aggressive tendencies, planned and extensive criminality, and psychopathic features.

2. Sophistication-maturity: these items tap into the areas of autonomy, cognitive capacities, and emotional maturity.

3. Treatment amenability: these items assess the degree and type of psychopathology, responsibility, and motivation to change, and consideration and tolerance of others.

F. Allows comparison of a juvenile’s score in three key areas to samples of juvenile offenders who have also been administered this assessment.

Example of treatment item number T6--“Takes Responsibility for Actions”

Michael is a 16-year-old boy facing charges of a rape of a 13-year-old girl, who was bruised during the assault and vaginally penetrated rupturing her hymen. When interviewed, he eventually states that he did engage in sexual intercourse with the girl but adds, “She wanted to have sex too.” He reports that he maybe misunderstood her and maybe she wasn’t coming on to him like he thought.

What score would Michael receive on this item?

0=Does not take responsibility
1=Takes some responsibility but tends to blame somewhat
2=Takes full responsibility for actions
XII. Juveniles and Desistance from Future Crime (Steinberg et al 2015)

A. The Pathways to Desistance study followed more than 1,300 serious juvenile offenders for 7 years after their conviction.

1. Most of the youth involved were between the ages of 14-18.
2. Youth were from Philadelphia County, PA and Maricopa County, AZ.
3. Used various measures to include three measures of psychosocial maturity.

   Temperance: The measures were self-reported impulse control (e.g., “I say the first thing that comes into my mind without thinking about it”) and suppression of aggression (e.g., “People who get me angry better watch out”). Both of these are subscales of the Weinberger Adjustment Inventory.

   Perspective: The measures were self-reported consideration of others (e.g. “Doing things to help other people is more important to me than almost anything else” and future orientation (e.g. “I will keep working at difficult, boring tasks if I know they will help me get ahead later.”)

   Responsibility: The measures were self-reported personal responsibility (e.g., “If something more interesting comes along, I will usually stop any work I’m doing) [taken from the Psychosocial Maturity Inventory] and resistance to peer influence (e.g., “Some people go along with their friends just to keep their friends happy, but other people refuse to go along with what their friends want to do, even though they know it will make their friends unhappy.”)

4. Involvement in antisocial behavior was assessed using the Self-Report of Offending, a widely used instrument in delinquency research. Participants reported if they had been involved in any of 22 aggressive or income-generating antisocial acts at baseline and at follow up periods.

B. Key findings:

1. Vast majority of juvenile offenders grow out of antisocial activity as they made the transition to adulthood.

2. Process of maturing out of crime is linked to the process of maturing more generally.

3. Individuals in the study differed in their level of psychosocial maturity and in the way they develop psychosocial maturity during adolescence and early adulthood. This variability in psychosocial maturity is linked to patterns of antisocial activity. Less mature individuals are more likely to be persistent offenders. These chronic offenders show a lack of psychosocial maturation that might be characterized as arrested development.
4. One important implication for practitioners is that interventions for juvenile offenders should be aimed explicitly at facilitating the development of psychosocial maturity and that special care should be taken to avoid exposing young offenders to environments that might inadvertently derail this developmental process.

XIII. **Policy implications:**

A. As the field of risk assessment/management and assessment of treatment amenability advances, practitioners and courts need to utilize assessments that are evidence-based, meaning that there is reasonable research evidence of the evaluation methodology’s reliability and validity and that the instruments are part of “best practices” in the forensic assessment.

B. For practitioners in the community, forensic consultants to the court can inform the court on the range of accepted evaluation methodologies for risk assessment/management and evaluation of treatment amenability, as well as the advantages and limitations of each.

C. Evaluators will need to follow structured assessment guidelines on user qualifications.

D. Courts could consider arranging training on best practices for community evaluators who have not had an opportunity to maintain current best practices evaluation methodology.

E. Training programs in child and adolescent psychiatry and psychology and forensic psychiatry and psychology should educate trainees on these instruments and provide specific training where appropriate.

F. Questions for the court to consider when assessment instruments are used include:

1. The age range used as the normative sample for the instrument (although not all structured tools have normative samples).

2. The population used to evaluate the instrument (i.e. community vs. delinquent population, age range, gender, race, culture, etc).

3. The known reliability and validity of the instrument.

4. The presence, if any, of any outcome data examining the utility of the instrument in the way that is being used for the specific referral.

5. The evaluator’s specific training and/or knowledge in administering and scoring the instrument.
6. A review of how each item was scored/calculated.

G. Using the RNR model, courts and evaluators need to understand the unnecessary financial burden and potential harm to the juvenile for over delivery of services to low risk or low need offenders. Likewise, courts should also be aware of the more intensive need for services for high risk/high need offenders.

XIV. Summary

A. Juvenile violence and school violence has decreased over the last decade.

B. Use of structured assessments can improve risk assessment and risk management.

C. Early intervention and matched intervention to level of need is vital.

References:


Forth AE, Kosson D, Hare RD. The Psychopathy Checklist; Youth Version. Toronto, Ontario, Canada: Multi-Health Systems, 2003


