

Diagnostic Changes to DSM-5: The Potential Impact on Juvenile Justice

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Legal decision-makers have discretion at every stage of processing in the juvenile justice system, and individual youth characteristics (e.g., a particular psychiatric diagnosis) influence how a youth progresses through the system. As a result, changes in diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) may affect the rates of diagnoses among justice-involved youths and subsequently influence youths' experiences within the justice system. In this article, we identify the diagnoses most likely to exert such influences and review the prevalence of diagnosis and psychiatric disorder symptomatology in justice-involved youths. We highlight the DSM-5 changes in diagnostic criteria for internalizing and externalizing disorders that commonly occur among justice-involved youths and the potential impact of these changes on the rates of diagnoses within this population. Finally, we address the limitations of using psychiatric diagnoses in juvenile justice decision making, including the potential for biasing legal decision-makers and the importance of considering context as part of diagnosis.

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Although juvenile justice procedures vary by jurisdiction, discretion is a hallmark of each stage of the juvenile justice process. As a result, a juvenile's characteristics can affect his experience in the system.¹ This article addresses the impact of one such characteristic, diagnosis of a psychiatric disorder, on a youth's juvenile justice involvement, focusing on the impact of recent changes to diagnostic criteria in the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition.²

For the purposes of this article, "psychiatric disorder," "mental disorder," and "behavioral health disorder" are all synonymous, referring to any disorder recognized in DSM-5. We have used the term psychiatric disorder throughout, but the reader should be aware of the breadth and scope of the intended meaning of that term in this context.

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Impact of Diagnosis on Stages of Juvenile Justice Involvement

Seventy percent of youths in juvenile detention centers³ and 46 percent of those assessed at probation intake meet criteria for at least one psychiatric disorder⁴ and therefore are at least eligible to receive a diagnosis. A psychiatric diagnosis may affect justice-involved youths at nearly every stage of juvenile justice proceedings, from arrest through adjudication. Given the substantial variation in procedures among juvenile justice systems nationwide, our discussion focuses on the most common processes experienced by justice-involved youths in the United States. We consider each stage of the typical juvenile justice process in the following sections.

Initial Intervention

When law enforcement officers respond to an incident involving youthful misconduct, they may have discretion to arrest the youth, issue a citation, or make no formal intervention.⁵ When officers perceive symptoms of a psychiatric diagnosis, they may consider that information when determining the individual's culpability and deciding whether to arrest.⁶ In addition, knowledge of an individual's psy-

chiatric diagnosis may influence officers' decisions, regardless of whether they directly perceive symptoms. Symptoms of a psychiatric disorder may also influence officers' decisions to transport a youth to a hospital or crisis center for treatment as an alternative to arrest.

One of the authors (EH-C) provided therapy to an adolescent who had been court ordered to receive mental health treatment from state services. His involvement in the juvenile justice system began when his parents called the police during an altercation in the home. After the parents informed the police of the child's diagnoses of attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD), the responding officers encouraged the parents to file assault charges against their son, under the premise that he would not receive state-provided mental health services unless such services were court ordered. The parents followed that advice, and the police arrested the child. Information related to diagnosis, therefore, may affect how police officers act when responding to calls, the recommendations they make to a juvenile's family, and whether they make an arrest.

Although we are not aware of any youth-specific research on such decisions, some authors have suggested that psychiatric diagnoses in adults can cut both ways: some officers may be more likely to take such adults to a hospital for treatment, whereas others may be more likely to arrest them to ensure provision of services in jail or prison.⁷

Informal Adjustment and Diversion

Once youths are arrested or issued a citation, they typically participate in intake procedures with a probation department or prosecutor's office.⁸ Intake outcomes can include dismissal, informal adjustment, or the filing of a formal petition to initiate court proceedings.⁹ Informal adjustment requires the juvenile and guardian to agree to certain conditions. When those conditions are met, the case is dismissed without formal adjudication.¹⁰ About half of juveniles have their cases dismissed or informally adjusted during intake.⁸

Juvenile justice personnel often obtain information about youths' mental health and substance use during the intake process.¹¹ However, intake probation officers in most jurisdictions receive little guidance regarding appropriate considerations and may be influenced by nonlegal factors. There is appar-

ently no research on whether a psychiatric diagnosis affects diversion decisions, but intake officers may consider diagnoses when making these preliminary judgments.

Detention Determination

In most jurisdictions, if a juvenile is not diverted from formal proceedings, intake or detention workers determine whether the youth should be detained or released, pending further court proceedings.⁸ An increasing number of jurisdictions have begun using structured risk assessment tools to guide this decision-making process, as they assess youths' risk to public safety and risk of failure to appear in court.¹² Such tools vary, but may include consideration of existing psychiatric diagnoses. Current policy recommendations suggest that psychiatric diagnoses should be addressed outside the detention setting.¹² Consequently, some assessment tools allow juvenile justice personnel to override a score indicating that detention is warranted if a youth has mental health problems. On the other hand, a substance abuse diagnosis may weigh in favor of detention.¹³

Youths detained after arrest receive a detention hearing that addresses the need for continued out-of-home placement before adjudication proceedings.¹⁴ In many jurisdictions, statutes authorizing preadjudicatory detention do not specify criteria for detention determinations,¹⁵ and judges may therefore consider psychiatric diagnoses. Research in laypeople indicates that children diagnosed with depression or ADHD are viewed as significantly more dangerous to themselves than are similar children labeled with a physical illness, such as asthma.¹⁶ Judges might make similar evaluations regarding a youth's dangerousness or safety and therefore detain juveniles with psychiatric diagnoses more often than comparable juveniles without such a diagnosis. However, there is no empirical research on this point at present.

Competence to Proceed

Some justice-involved youths present questions about competence to proceed through the adjudicative process (i.e., adjudicative competence). Although there is no national consensus on youth adjudicative competence,¹⁷ competence typically requires rational and factual understanding of the proceedings and the ability to assist counsel.¹⁸ Courts often focus on mental illness and intellectual

disability as threshold concerns when considering a defendant's adjudicative competence.¹⁹ Research in youths has demonstrated an association between ADHD symptoms and reduced ability to communicate with counsel.¹⁷ If judges are aware of these findings, they may be particularly likely to consider diagnoses when making competence determinations for juveniles. However, even if unfamiliar with the research, judges may still assume that a psychiatric disorder can affect competence and therefore may take diagnosis into account. Although prior inpatient or outpatient mental health treatment has been linked to determinations about youths' competency, many juveniles found to lack competence do not meet criteria for a psychiatric diagnosis other than intellectual disability,²⁰ suggesting that this particular diagnosis may play the biggest role in competency determinations for youths.

Capacity to Waive Miranda Rights

Miranda rights waivers must be knowing, intelligent, and voluntary.⁷ Courts may consider the juvenile's age, experience, education, background, and intelligence when evaluating such a waiver.²¹ Researchers have not identified a significant relationship between capacity to waive interrogative rights and symptoms of depression, anxiety, or behavior problems.¹⁷ However, regardless of whether mental illness actually predicts incapacity to waive *Miranda* rights, judges may still consider it a factor under the totality of the circumstances, an approach that considers the situational context of the warning, waiver, interrogation, and suspect characteristics.²²

Adjudicatory Hearing

Juveniles who are competent to proceed next face an adjudicatory hearing. Although there is some evidence that suggests that juvenile justice systems are becoming more punitive and thus more "criminal,"²³ juvenile systems nationwide continue to assert a focus on rehabilitation. As a result, a finding of delinquency in many jurisdictions generally requires not only that the charges against a juvenile defendant be proved beyond a reasonable doubt, but also that the youth be in need of treatment, rehabilitation, or both.²⁴ Certainly, a psychiatric diagnosis, which may require treatment, provides legal decision-makers with relevant information to answer this question.

Disposition

After a juvenile's adjudication, most jurisdictions assign probation officers to prepare disposition recommendations before the disposition hearing. Courts may order a psychological evaluation to determine whether a defendant meets criteria for a psychiatric diagnosis that would affect his treatment needs.⁸ Although recent juvenile justice reforms have attempted to reduce the use of out-of-home placements for youths,²⁵ available research in this area suggests that judges consider diagnostic information when ordering a particular disposition. For example, youths diagnosed with substance abuse or dependence are more likely to receive a disposition including residential placement.²⁶ Previous outpatient drug or mental health treatment has also been linked to disposition severity.²⁷ In addition, youths with higher reported intellectual functioning are more likely to receive probation over facility commitment,²⁶ whereas secure placement is more common among youths with problems at school.²⁸ These findings may suggest that intellectual disability symptomatology increases the risk of confinement. Finally, when a child has a formal psychiatric diagnosis, judges may be more likely to incorporate mental health or substance abuse treatment into the disposition.²⁹ Some of the impact of psychiatric diagnosis on disposition may be explained by clinician recommendations. One study found that externalizing disorders accounted for a significant portion of variance in clinicians' recommendations to judges, which in turn accounted for more than half of the variance in judges' decisions regarding disposition.²⁸

Waiver, Transfer, and Certification

There are multiple mechanisms through which juveniles can be tried in criminal courts (e.g., judicial waiver of juvenile court jurisdiction, statutory exclusion of certain crimes from juvenile court). In addition, juveniles initially charged as adults may, in some jurisdictions, request that the criminal court hold a decertification hearing to determine whether the case would be more appropriately handled by the juvenile court.⁸ Notably, studies comparing characteristics of youths from both types of courts have revealed that those processed in criminal court, regardless of the mechanism of transfer, have similar, or even more severe, mental health needs than those tried in the juvenile system.³⁰

When determining the appropriate forum for a case, judges consider whether the juvenile system can adequately serve the youth's needs while maintaining public safety. Most jurisdictions have adopted transfer criteria using the Supreme Court's language from *Kent*: "the sophistication and maturity of the juvenile," "the likelihood of reasonable rehabilitation of the juvenile," and "whether the protection of the community requires waiver."³¹ State statutes usually also require that judges directly consider mental illness, treatment needs, and treatment amenability.³² However, in jurisdictions in which juveniles have no right to request judicial review of prosecutorial transfers to criminal court, a behavioral health diagnosis may not be known or considered by prosecutors making transfer decisions.

Forensic evaluations pertaining to transfer decisions are likely to include information about psychiatric diagnoses and may relate youths' diagnoses to factors such as risk to community or rehabilitation potential. When surveyed, most judges have rated treatment amenability information in such reports as highly useful.³³ However, judges seem to give significantly less weight to treatment amenability than to dangerousness or sophistication and maturity,³³ suggesting that diagnosis has the greatest impact on transfer decisions when judges believe it is relevant to public safety.

Prevalence of Psychiatric Disorders Among Justice-Involved Youths

Disproportionately higher rates of psychiatric disorder diagnoses occur within the juvenile justice population (e.g., up to 70%³⁴) relative to youths in the general population (e.g., 9–13%³⁵). Given the recent release of DSM-5,² there are few published studies providing prevalence estimates based on revised diagnostic criteria. Consequently, questions about how diagnostic changes in DSM-5 will affect the prevalence of psychiatric diagnoses among justice-involved youths and how these diagnoses influence the youths' experiences within the juvenile justice system cannot be fully answered. Below, we discuss common psychiatric diagnoses within the juvenile justice population and how DSM-5 diagnostic changes may affect assessment, identification, and treatment of these psychiatric disorders among justice-involved youths. We have summarized relevant diagnostic changes and their potential impact on juvenile justice populations in Table 1; however, we

will provide in-depth discussion of only the most relevant changes.

Internalizing Disorders

Many justice-involved youths meet criteria for one or more internalizing disorders, which are characterized by prominent anxious, depressive, and somatic symptoms. In a study of 7,073 pre- and post-adjudication youths, more than half of confined youths reported current anxiety and depression symptoms; 32 percent reported anhedonia.³⁶ Other studies have found that female justice-involved youths, more so than males, demonstrate elevated internalizing symptoms, especially anger, depression and anxiety, somatic complaints, and suicidal ideation. Although empirical research has revealed that youths tend to report high levels of internalizing symptoms, estimates of internalizing disorder diagnoses among justice-involved youths are not as elevated.³⁶ According to criteria in the Fourth Edition of DSM, Revised (DSM-IV-TR), 16 percent of court-involved, nonincarcerated youths met criteria for affective disorders, and 11 percent met criteria for anxiety disorders.³⁷

Affective Disorders

One of the most striking DSM-5 changes was the separation of the DSM-IV-TR "Mood Disorders" chapter into two chapters: "Depressive Disorders" and "Bipolar and Related Disorders." These chapters, like many others in DSM-5, now include specifier categories ("other specified" and "unspecified"), which allow clinicians to diagnose individuals who present with unclear or undifferentiated cases of a disorder.² Developmental changes occurring in adolescence (e.g., nascent verbal skills and increased valuation of social desirability) may hinder youths from accurately describing their symptoms.³⁸ This change may increase the rates of mood disorder diagnosis among justice-involved youths who may otherwise fall short of meeting necessary diagnostic criteria.

Bipolar and related disorders. The DSM-5 criteria for manic and hypomanic episodes include new requirements: "persistently increased goal-directed activity or energy" (mania) and "persistently increased activity or energy" (hypomania) (Ref. 2, p 124). Thus, youths exhibiting elevated or irritable mood alone may be less likely to receive a bipolar disorder diagnosis. In addition, the symptoms of a manic episode must "represent a noticeable change from usual

Table 1 Changes in DSM-5 Relevant to Juvenile Justice Populations

Diagnosis	DSM-IV-TR Criteria	DSM-5 Criteria	Potential Impact
Internalizing disorders			
Bipolar disorder I/II	Manic episode described as period of "abnormally and persistently elevated, expansive, or irritable mood"	Manic episode described using abnormalities in mood and goal-directed activity or energy	Youths exhibiting elevated or irritable mood alone (i.e., without increased energy) may be less likely to receive a bipolar disorder diagnosis
	No indication of behavior representing a distinct change.	Manic behavior must "represent a noticeable change from usual behavior."	May result in fewer bipolar diagnoses among youths with comorbid diagnoses resulting in high energy and irritable mood
Disruptive mood dysregulation disorder (DMDD)	N/A (new diagnosis in DSM-5)	Characterized by recurring severe temper outbursts and persistently irritable mood between outbursts; excludes coexisting ODD, IED, or bipolar disorder	May result in fewer bipolar disorder diagnoses and therefore reduce use of atypical antipsychotic medications in this population
Major depressive disorder (MDD)	Depressed mood described as feeling sad or empty	Depressed mood described as feeling "sad, empty, or hopeless"	May increase MDD diagnosis among youths who suppress the appearance of sadness to better survive in hostile environments
	N/A	Added new specifier: "with anxious distress"	May increase attention to anxiety symptoms in youths with MDD, which has been linked to increased suicide risk
	N/A	Added new specifier: "with peripartum onset"	May be particularly relevant for diagnosing depression in female justice-involved youths, a growing group in the juvenile justice system
Persistent depressive disorder (PDD)	N/A (new diagnosis in DSM-5)	Consolidates dysthymic disorder and chronic MDD from DSM-IV; MDEs can be noted via specifier	Overlapping criteria for MDD and PDD may complicate diagnostic picture for youths who lack insight into how long they have experienced these symptoms
Posttraumatic stress disorder (PTSD)	Classified as an anxiety disorder	Classified as a trauma- and stressor-related disorder	Appears to emphasize the unique characteristics of trauma-related disorders
	Traumatic event must be accompanied by reactions of intense fear, helplessness, or horror	This requirement has been removed in DSM-5	May promote PTSD diagnosis among youths who demonstrate varied immediate reactions to trauma, especially those with repeated exposure
Separation anxiety disorder	Included three symptom clusters: re-experiencing, avoidance/numbing, arousal	Separated avoidance and numbing clusters; added persistent negative emotional states	May better contextualize apparent externalizing behaviors (e.g., substance use) that often arise after exposure to trauma
	Arousal symptom cluster did not include "reckless or self-destructive behavior"	DSM-5 has added "reckless or self-destructive behavior" to arousal and reactivity cluster	
	Onset before age 18	Onset can be after 18	May improve diagnostic accuracy for young adults (18–21) under juvenile court supervision for delinquent acts they committed before age 18
Somatic symptom disorder (SSD)	Somatization disorder; hypochondriasis; pain disorder	No longer requires a specific number of complaints; somatic symptoms no longer must be medically unexplained	May increase the number of SSD diagnoses among justice-involved youths

Table 1 (Continued)

Diagnosis	DSM-IV-TR Criteria	DSM-5 Criteria	Potential Impact
Externalizing disorders			
Attention-deficit hyperactivity disorder (ADHD)	Onset before 7 years of age	Onset before 12 years of age	Given potentially confounding influence of other major life events (i.e., puberty, transition to secondary school) occurring around the same stage in development, may promote false positive diagnoses among justice-involved youths
	Excluded autism as a comorbid diagnosis	Allows comorbid autism diagnosis	May promote a better understanding of justice-involved youths' social dysfunction, disengagement, and inattention to authority; may also allow for more effective management of youths' disruptive behavior during justice system transitions
	Symptoms must be present in two or more settings (i.e., school, work, home)	Allows for symptom observation in additional situations (e.g., with relatives or friends)	Reduces emphasis on particular settings where stressors like trauma may better account for symptoms
	N/A	Adds severity specifiers (i.e., mild, moderate, severe)	May provide more clinically relevant information and assist in identifying treatment needs
Conduct disorder (CD)	N/A	Adds "with limited prosocial emotions" specifier	May impress upon juvenile justice decision makers that youths with such a specifier are not amenable to treatment
Intermittent explosive disorder (IED)	Emphasized physical acts of aggression in description of behavioral outbursts	Includes physical, verbal and noninjurious/nondestructive aggression in description	May improve understanding of the increasingly high rates of female youths, who may be more likely than males to engage in other forms of aggression, entering the juvenile justice system for anger-based, violent crimes, such as robbery, aggravated assault, and murder
	Outbursts must be of low frequency/high intensity	Outbursts may also be of high frequency/low intensity	May increase IED diagnosis among justice-involved youths; may also improve understanding and treatment of youths who chronically reoffend through aggressive acts not better explained by situational factors (e.g., attainment of basic human needs such as food, money, shelter)

Table 1 (Continued)

Diagnosis	DSM-IV-TR Criteria	DSM-5 Criteria	Potential Impact
Oppositional defiant disorder (ODD)	N/A Required a pattern of negativistic, hostile, and defiant behavior Required frequency not discussed	Problematic behaviors must occur with at least one non sibling individual Groups symptoms into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness Requires that symptoms occur at least once per week Adds severity specifiers (i.e., mild, moderate, severe) based on the number of settings in which symptoms occur	Disregards context-specific variables that may promote delinquency Emphasizes oppositional mood or attitude in addition to behavior; increases likelihood of ODD diagnosis Decreases likelihood of ODD diagnosis for youths who occasionally exhibit oppositional behavior May provide more clinically relevant information and assist in identifying treatment needs
Substance use disorders (SUDs)	N/A Recurrent substance use must contribute to distress or impairment in several situations (e.g., legal problems); separate abuse and dependence criteria	Removes legal difficulties requirement and combines abuse and dependence criteria Adds "risky use" criterion ("recurrent use in situations in which it is physically hazardous") Requires the presence of two symptoms in a 12-month period	May result in overdiagnosis in justice-involved youths, given that changes do not include specifiers that recognize adolescent physiological sensitivity to, and heterogeneous, subtle patterns of, tolerance and withdrawal May overemphasize developmentally normative sensation-seeking and experimentation; may result in overdiagnosing SUDs in justice-involved youths

behavior" (Ref. 2, p 124), which was not included in earlier DSM versions. Together, these changes may reduce the prevalence of bipolar diagnoses among justice-involved youths.

Disruptive mood dysregulation disorder. Earlier DSM versions did not classify severe, nonepisodic irritability in youths as a distinct form of psychopathology.² The disruptive mood dysregulation disorder (DMDD) diagnosis distinguishes youths whose hallmark symptoms are chronic, persistent irritability from others who exhibit irritable behaviors specific to bipolar disorder (see Table 1).² Given the upsurge in pediatric bipolar disorder diagnoses over the past two decades, some experts have speculated that clinicians have been using one diagnosis (i.e., bipolar disorder) to describe the observation of two distinct clinical presentations (i.e., severe, nonepisodic irritability and episodic mania).² Misdiagnosis of DMDD as bipolar disorder may be particularly problematic, because bipolar disorder is often treated with atypical antipsychotic medications.³⁹ Although these medications have become standard treatment for pediatric dysregulated behavior, associated side effects should limit their use, as they may also present physical health complications in adulthood if used for the long term.³⁹ Thus, appropriate diagnosis of DMDD may foster use of other interventions meant to improve emotion management.

Major depressive disorder. Revisions to diagnostic criteria for major depressive disorder (MDD) may hold positive implications for identifying depression in justice-involved youths. First, MDD criteria now include hopelessness in the absence of sadness as a subjective descriptor of depressed mood.² This change may be particularly relevant in youths who suppress the appearance of sadness to survive in environments requiring them to appear confident and remain vigilant (e.g., neighborhoods with heightened violence). Allowing youths to meet criteria for MDD without feeling sad may ensure that those whose hopelessness contributes to delinquent behavior are better identified and may increase their likelihood of referral for appropriate treatment.

The inclusion of two new MDD specifiers may also alert clinicians to other internalizing symptoms relevant to diagnosis and treatment in justice-involved youths. The "with anxious distress" specifier increases attention to anxiety symptoms in

youths meeting criteria for MDD, which is particularly relevant, given that anxiety has been strongly associated with increased risk of suicide⁴⁰ and justice-involved youths have an increased likelihood of committing suicide compared with community youths.⁴¹ The “with peripartum onset” specifier reflects growing evidence that depressive episodes often begin in pregnancy. This specifier may be particularly salient to diagnosing depression in female juvenile offenders who are at increased risk of pregnancy and childbearing in adolescence⁴² and whose presence in the juvenile justice system has increased substantially since the early 1990s.⁴³

Posttraumatic Stress Disorder

An increased prevalence of posttraumatic stress disorder (PTSD) among justice-involved youths is consistent with their high rates of trauma exposure.⁴⁴ With an average of about 14 distinct lifetime traumas,⁴⁵ justice-involved youths frequently report experiencing physical and sexual abuse and witnessing violence.⁴⁴ Further, placing highly traumatized youths into restrictive settings with intimidating and aggressive peers and authority figures may exacerbate symptoms of posttraumatic stress and potentially increase their likelihood of developing other internalizing disorders.⁴⁴

DSM-5 now classifies PTSD as one of several trauma- and stressor-related disorders, rather than an anxiety disorder. In addition, two of the revisions to the PTSD diagnostic criteria are particularly relevant for justice-involved youths. First, DSM-5 eliminates Criterion A2, specifying that a traumatic event “must be accompanied by subjective peritraumatic reactions of intense fear, helplessness, or horror” (Ref. 46, p 467). This change broadens the scope of PTSD from a disorder marked by fear to one inclusive of anhedonic/dysphoric and externalizing phenotypes, thereby including youths who may respond to trauma by engaging in antisocial or delinquent behavior.⁴⁷ Second, DSM-5 expands PTSD symptom clusters from three to four categories, separating avoidance from numbing symptoms and adding a new symptom category, negative cognitions and mood, which includes persistent negative evaluation of self and others, elevated self-blame, negative emotional state, and reckless or self-destructive behavior.² Recognizing these symptoms when considering a PTSD diagnosis may better contextualize externalizing behaviors, such as substance use, that often arise

after exposure to trauma. This change has the potential to increase PTSD diagnosis rates and promote implementation of trauma-informed care within juvenile justice settings.^{44,47}

For discussion of additional internalizing disorders (i.e., persistent depressive disorder, separation anxiety disorder, and somatic symptom disorder), see Table 1.

Externalizing Disorders

Commonly diagnosed externalizing disorders among justice-involved youths include disruptive behavior disorders, such as oppositional defiant disorder (ODD) and conduct disorder (CD), ADHD, and substance use disorders (SUDs).³⁷ Prevalence rates for externalizing disorders among justice-involved youths range from 20 to 60 percent across various settings,^{4,34,37} which underscores the significance of changes to these diagnostic criteria.

Disruptive Behavior Disorders

Across studies of justice-involved youths, 15 to 18 percent of youths met criteria for CD and 6 to 23 percent met criteria for ODD diagnosed according to DSM-IV-TR criteria.³⁷ The DSM-5 revisions to criteria for disruptive behavior disorders are subtle, but may influence the prevalence of comorbidity among disorders comprising this diagnostic class.

Oppositional defiant disorder. The DSM-5 changed the first diagnostic criterion of ODD from a pattern of “negativistic, hostile, and defiant behavior” (Ref. 46, p 102) to one of “angry/irritable mood, argumentative/defiant behavior, or vindictiveness” (Ref. 2, p 462). The new criterion means that youths who would have fallen short of DSM-IV-TR criteria because they exhibit oppositional mood or attitude rather than behaviors would now receive such a diagnosis. In addition to specifying the frequency of symptoms, DSM-5 has added severity specifiers for ODD that may make the diagnosis more useful to justice system personnel who are conceptualizing and treating youths’ behaviors (see Table 1).

Conduct disorder. CD diagnoses can now be augmented with a new specifier (“with limited prosocial emotions”) if the child displays at least two of the following characteristics over the course of at least 12 months: lack of remorse or feelings of guilt, callous-

ness and lack of empathy, lack of concern about performance in important activities, or shallow and deficient affect.² This specifier could suggest to legal decision makers that a particular youth is not amenable to treatment, although additional research is needed to evaluate the accuracy of this perception.

ADHD

Approximately 17 percent of male and 21 percent of female detained youths met criteria for ADHD based on the Third Edition of DSM, Revised (DSM-III-R)⁴⁸ criteria,⁴⁹ and more than 40 percent of youths reported difficulty paying attention, with other ADHD symptoms also frequently endorsed.³⁶ DSM-5 increases the maximum age of symptom onset for ADHD from 7 to 12 years.^{2,46} This shift was intended to increase accurate diagnosis of ADHD in adolescents and adults⁵⁰; however, it may also promote false-positive diagnoses of ADHD among youths, especially given the potentially confounding influence of other major life events (i.e., puberty, transition to secondary school) occurring around the same time.⁵¹ For example, changes in neurotransmitter functioning during puberty may better explain abnormal behavior in adolescents than would a diagnosis of ADHD.⁵² Should this change in age of onset increase ADHD prevalence rates, there may be a concomitant increase in psychostimulant treatment,⁵³ potentially escalating rates of SUDs within justice-involved youths, given this population's heightened vulnerability to substance abuse.³⁶

Conversely, several DSM-5 revisions to ADHD may benefit justice-involved youths. The exclusion of autism spectrum disorder was removed from ADHD, youths' inattentive or hyperactive-impulsive symptoms were emphasized across multiple settings, and severity specifiers were added to the diagnosis (see Table 1).

Substance Use Disorder

More than a third of justice-involved youths meet DSM-IV-TR criteria for drug or alcohol abuse/dependence, a rate three to four times higher than estimates for similarly aged community youth samples.⁵⁴ Extensive examination of the prevalence of SUDs within the juvenile justice population reveals an association between increased risk of recidivating and presence of an SUD⁵⁵ and greater prevalence of SUDs among youths with more extensive justice system involvement.^{41,56} DSM-5 criteria seem to have strengthened the manual's utility in diagnosing

SUDs in youths by eliminating the former "legal difficulties" section and combining the abuse and dependence criteria. However, the addition of the "risky use" criterion set and the two-symptom threshold (see Table 1) seem to overemphasize developmentally normative sensation seeking and experimentation, both of which have a high potential for remittance⁵⁷ and mistake related behaviors as reflecting drug dependency. These changes may lead to clinicians overdiagnosing SUDs in justice-involved youths.

Impact of DSM-5 Diagnostic Changes on Youth Involvement in the Juvenile Justice System

Given the large numbers of justice-involved youths with psychiatric disorders,³⁴ judges and clinicians should consider the impact changes to DSM-5 diagnostic criteria may have on defining and labeling psychopathology among justice-involved youths. For example, changes that may increase prevalence rates of certain disorders, such as PTSD and ODD, may allow youths who would have fallen short of a diagnosis under DSM-IV-TR to meet criteria, increasing decision-makers' attention to a youth's specific treatment needs. On the other hand, increases in the prevalence of certain diagnoses (e.g., ADHD) may also escalate the use of psychostimulant medications, which have a high potential for addiction^{54,57} that may place youths at greater risk of developing SUDs. In addition, changes to DSM-5 diagnostic criteria intended to broaden the scope of specific disorders (e.g., MDD) may fall short of accurately capturing a youth's psychological distress, particularly when typical adolescent cognitive and psychosocial processes hinder the youth from exercising introspection and conveying symptomatology. Further, clinicians may be less motivated to consider diagnosing newly introduced disorders in youths (e.g., DMDD), given the lack of reliable and empirically supported tools designed to assess and treat those disorders.

For several externalizing disorders (e.g., CD and ADHD), DSM-5's broadened diagnostic criteria may result in judges viewing more youths as not amenable to treatment and, therefore, at greater likelihood of reoffending. Thus, judges may impose more restrictive dispositions on youths, subjecting some low-risk youths to unnecessary costly and intensive interventions (i.e., secure facility commitment).

However, some changes in both internalizing and externalizing disorder criteria may facilitate clinical insight into the increasing number of female justice-involved youths and may improve understanding of those who chronically reoffend. Overall, changes in DSM-5 diagnostic criteria pose potentially positive and negative outcomes for youths throughout the juvenile justice system; however, it is important to recognize that the potential impact of these diagnostic changes will not necessarily address the general limitations of applying psychiatric diagnoses to justice-involved youths.

Limitations of Diagnosis for Juvenile Justice Decision Making

Although psychiatric diagnoses may impact juveniles' paths through the justice system, it is important to recognize that diagnoses rarely answer the legal questions associated with forensic evaluations. Indeed, DSM-5 explicitly cautions against conflating diagnosis and legal problems.² Therefore, although diagnosis may be relevant to answering a legal question, diagnosis alone will never be sufficient to address a youth-specific legal matter. Further, it is also possible that diagnosis will be largely irrelevant to certain legal situations.

A threshold concern in forensic evaluations of juveniles is the necessity of including a diagnosis.⁵⁸ Guidance in this context comes from relevant legal statutes or case law that structure the legal question and resulting evaluation. Certain legal problems require a diagnosis as a necessary prerequisite to applying a legal standard. For instance, in the case of competence to stand trial, most jurisdictions implicitly or explicitly require that deficits be related to underlying mental disorder or cognitive disability.⁵⁹ Some diagnoses may be particularly germane to a given legal question. For the nearly 50 percent of youths in detention who meet criteria for an SUD diagnosis,⁴⁹ such a diagnosis may be relevant to detention, adjudication, disposition, and waiver/transfer decisions, given the correlation between substance abuse and both recidivism and violence.⁶⁰

However, even in cases when diagnosis is necessary or relevant, a diagnosis will never fully address the legal situation. Scholarship and best-practice guidelines in the area of forensic mental health assessment emphasize that clinicians should explain the relationship between mental health symptoms and relevant functional capacities.⁵⁸ Even a diagnosis as

severe as schizophrenia, for example, does not fully address a juvenile's risk of future dangerousness, amenability to treatment, or adjudicative competence. It is also possible that certain diagnoses will be irrelevant or even misleading. For instance, that a youth meets criteria for CD provides no meaningful information about adjudicative competence or *Miranda* waiver validity.

In general, the risks associated with diagnoses can be greater for a youth if certain traits or behaviors are described as fixed rather than transient.⁶¹ The juvenile risk assessment literature addresses the common phenomenon of adolescent-limited antisocial or criminal behavior.⁶² Further, some have suggested that certain diagnoses, particularly CD and psychopathy, may bias decision makers. One study demonstrated that juvenile probation officers rated youths with CD as slightly more likely to recidivate than youths with no diagnosis.⁶¹ Similarly, a diagnosis of psychopathy may cause clinicians to describe the individual as less amenable to treatment, and judges may be more likely to think that such juveniles should be tried as adults.⁶³ A psychopathy diagnosis also relates to judicial perceptions of a juvenile's dangerousness.⁶⁴

Given empirical and theoretical concerns about the biasing effects of these diagnoses, scholars have debated whether they are appropriate or convey meaningful information. For instance, many have raised concerns that a CD diagnosis may merely indicate that a youth engaged in the sort of activity that led to justice involvement.⁶⁵ Thus, assigning the diagnosis to a youth already in the system is redundant and may obscure more relevant information about treatment needs. Others have argued that the psychopathy diagnosis is so stigmatizing to justice-involved youths that the label should not be used.⁶⁶ Still others, however, have noted that juvenile psychopathy correlates with adult criminality⁶⁷ and therefore may reasonably inform legal decision-makers. Some researchers have also emphasized the impact of behavioral descriptions over the impact of diagnostic labels.⁶¹ As research in this area continues to develop, forensic evaluators should consider the necessity of diagnosis, the relevance of diagnosis to the legal question, the relationship between symptoms and functional capacities, and the possibility of stigmatizing effects.

Conclusion

Youths entering the juvenile justice system demonstrate disproportionate rates of traumatic exposure, substance use, and other mental health needs in comparison to nonoffending youths.^{37,44,56} Given the significant amount of discretion afforded personnel at various stages of the process, such characteristics can affect youths throughout their juvenile justice involvement. Although DSM diagnoses may help clinicians and other decision makers better understand and assign interventions to justice-involved youths, they may also elicit biases and result in outcomes that do not reflect the youths' best interests. As a result, it is imperative that clinicians correctly assess and identify psychiatric symptoms and make associated diagnoses at various stages of the juvenile justice process using diagnostic criteria that are specific, relevant, and accurate.

Given its recent release, many of DSM-5's potential effects on justice-involved youths are, as yet, untested, and it remains to be seen whether revised criteria will fulfill the needs of clinicians, legal decision makers, and justice-involved youths. Future research in this area should quantitatively investigate the impact of DSM-5's revised diagnostic criteria within the population of justice-involved youths. Of course, both absolute and relative (i.e., to DSM-IV-TR) prevalence rates are of interest; analyses with relative data could explore whether changes are in the hypothesized directions and whether new diagnoses are being used appropriately and reduce some of the heterogeneity in other diagnoses. Further, although changes in formal diagnostic criteria are certainly of interest to academics and researchers, overworked case managers and treatment providers in juvenile justice systems may understandably be less attentive to these matters, particularly to the more nuanced changes. Future research should therefore explore how juvenile justice system personnel use psychiatric diagnoses in the youths that they assess and treat, including the use of specifiers that communicate meaningful clinical information but could easily be overlooked. Finally, the relationship between diagnosis and different intervention variables (e.g., dose, modality) should be investigated, given that improved treatment outcomes serve as an ultimate goal of any diagnostic system revision. Findings from such research will inform legal decision makers and enhance juvenile justice systems' effectiveness in ad-

ressing the mental health needs of youths in their care.

References

1. Rosenheim MK: The modern American juvenile court, in *A Century of Juvenile Justice*. Edited by Rosenheim MK, Zimring FE, Tanenhaus DS, et al. Chicago: University of Chicago Press, 2002, pp 341–58
2. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association, 2013
3. Shufelt JL, Cocozza JJ: *Youth With Mental Health Disorders in the Juvenile Justice System: Results From a Multi-State Prevalence Study*. Delmar, NY: National Center for Mental Health and Juvenile Justice, 2006
4. Wasserman GA, McReynolds LS, Ko SJ, et al: Gender differences in psychiatric disorders at juvenile probation intake. *Am J Public Health* 95:131–7, 2005
5. Jagers J, Young S, Church WT: Police work with juveniles, in *Juvenile Justice Sourcebook* (ed 2). Edited by Church WT, Springer DW, Roberts AR. New York: Oxford University Press, 2014, pp 149–66
6. Novak KJ, Engel RS: Disentangling the influence of suspects' demeanor and mental disorder on arrest. *Policing* 28:493–512, 2005
7. Lamb HR, Weinberger LE, DeCuir WJ Jr: The police and mental health. *Psychiatr Serv* 53:1266–71, 2002
8. Snyder HN, Sickmund M: *Juvenile Offenders and Victims: 2006 National Report*. Washington, DC: U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention, 2006
9. Panzer C: Reducing juvenile recidivism through pre-trial diversion programs: a community's involvement. *J Juv L* 18:186–207, 1997
10. 42 Pa. Cons. Stat. Ann. § 6323 (2007)
11. Birkhead TR: Closing the widening net: the rights of juveniles at intake. *Tex Tech L Rev* 46:157–86, 2013
12. Steinhart D: *A practice guide to juvenile detention reform: juvenile detention risk assessment*. Baltimore: Annie E. Casey Foundation, 2006
13. Puzanchera C, Knoll C, Adams B, et al: *Allegheny County detention screening study*. Pittsburgh: National Center for Juvenile Justice, 2012
14. Kramer DT. 2 *Legal Rights of Children Review*. 2014;2D § 22:5 (2d ed.)
15. Conklin S: Juveniles locked in limbo: why pretrial detention implicates a fundamental right. *Minn L Rev* 96:2150–81, 2011
16. Pescosolido BA, Fettes DL, Martin JK, et al: Perceived dangerousness of children with mental health problems and support for coerced treatment. *Psychiatr Serv* 58:619–25, 2007
17. Viljoen JL, Roesch R: Competence to waive interrogation rights and adjudicative competence in adolescent defendants. *Law & Hum Behav* 29:723–42, 2005
18. *Dusky v. United States*, 362 U.S. 402, 403 (1960)
19. Grisso T, Steinberg L, Woolard J, et al: Juveniles' competence to stand trial: a comparison of adolescents' and adults' capacities as trial defendants. *Law & Hum Behav* 27:333–63, 2003
20. Baerger DR, Griffin E, Lyons J, et al: Competency to stand trial in preadjudicated and petitioned juvenile defendants. *J Am Acad Psychiatry Law* 31:314–20, 2003

21. *Fare v. Michael C.*, 442 U.S. 707, 725 (1979)
22. Goldstein NES, Condie LO, Kalbeitzer R: Instruments for assessing understanding and appreciation of Miranda rights, in *Mental Health Screening and Assessment in Juvenile Justice*. Edited by Grisso T, Vincent G, Seagrave D. New York: Guilford Press, 2005, pp 357–69
23. Gardner MR: Punitive juvenile justice and public trials by jury: Sixth Amendment applications in a post-McKeiver world. *Neb L Rev* 91:1–71, 2012
24. Pa. R. J. C. P. 409 (2014)
25. Lee BR, Ebesutani C, Kolivoski KM, *et al*: Program and practice elements for placement prevention: a review of interventions and their effectiveness in promoting home-based care. *Am J Orthopsychiatry* 84:244–56, 2014
26. Cauffman E, Piquero AR, Kimonis E, *et al*: Legal, individual, and environmental predictors of court disposition in a sample of serious adolescent offenders. *Law & Hum Behav* 31:519–35, 2007
27. Schwalbe CS, Hatcher SS, Maschi T: The effects of treatment needs and prior social services use on juvenile court decision making. *Soc Work Res* 33:31–40, 2009
28. O'Donnell PC, Lurigio AJ: Psychosocial predictors of clinicians' recommendations and judges' placement orders in a juvenile court. *Crim Just & Behav* 35:1429–48, 2008
29. NeMoyer A, Goldstein NE, McKitten RL, *et al*: Predictors of juveniles' noncompliance with probation requirements. *Law & Hum Behav* 38:580–91, 2014
30. Murrie DC, Henderson CE, Vincent GM, *et al*: Psychiatric symptoms among juveniles incarcerated in adult prison. *Psychiatr Serv* 60:1092–7, 2009
31. *Kent v. United States*, 383 U.S. 541, 566–567 (1966)
32. Heilbrun K, Leheny C, Thomas L, *et al*: A national survey of US statutes on juvenile transfer: implications for policy and practice. *Behav Sci & L* 15:125–49, 1997
33. Brannen DN, Salekin RT, Zapf PA, *et al*: Transfer to adult court: a national study of how juvenile court judges weigh pertinent Kent criteria. *Psychol Pub Pol'y & L* 12:332–55, 2006
34. Fazel S, Doll H, Långström N: Mental disorders among adolescents in juvenile detention and correctional facilities: a systematic review and metaregression analysis of 25 surveys. *J Am Acad Child Adolesc Psychiatry* 47:1010–19, 2008
35. Wasserman GA, Ko SJ, McReynolds LS: Assessing the mental health status of youth in juvenile justice settings. Washington, DC: U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention, 2004
36. Sedlak A, McPherson K. Youth's needs and services. *FBI Law Enforce Bull* 79:22, 2010
37. Tolou-Shams M, Rizzo CJ, Conrad SM, *et al*: Predictors of detention among juveniles referred for a court clinic forensic evaluation. *J Am Acad Psychiatry Law* 42:56–65, 2014
38. Duncan BL, Sparks JA, Miller SD, *et al*: Giving youth a voice: a preliminary study of the reliability and validity of a brief outcome measure for children, adolescent, and caretakers. *J Brief Therapy* 5:71–88, 2006
39. Roy AK, Lopes V, Klein RG: Disruptive mood dysregulation disorder: a new diagnostic approach to chronic irritability in youth. *Am J Psychiatry* 171:918–24, 2014
40. Bjerkeset O, Romundstad P, Gunnell D: Gender differences in the association of mixed anxiety and depression with suicide. *Br J Psychiatry* 192:474–5, 2008
41. Wasserman GA, McReynolds LS, Schwalbe CS, *et al*: Psychiatric disorder, comorbidity, and suicidal behavior in juvenile justice youth. *Crim Just & Behav* 37:1361–76, 2010
42. Kerr DC, Leve LD, Chamberlain P: Pregnancy rates among juvenile justice girls in two randomized controlled trials of multidimensional treatment foster care. *J Consult Clin Psychol* 77:588–93, 2009
43. Snyder H: *Juvenile Arrests 2006 Bulletin*. Washington, DC: U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention, 2008
44. Espinosa EM, Sorensen JR, Lopez MA: Youth pathways to placement: the influence of gender, mental health need and trauma on confinement in the juvenile justice system. *J Youth Adolesc* 42: 1824–36, 2013
45. Abram KM, Teplin LA, Charles DR, *et al*: Posttraumatic stress disorder and trauma in youth in juvenile detention. *Arch Gen Psychiatry* 61:403–10, 2004
46. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000
47. Wasserman GA, McReynolds LS: Contributors to traumatic exposure and posttraumatic stress disorder in juvenile justice youths. *J Traum Stress* 24:422–9, 2011
48. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. Third Edition, Revised. Washington, DC: American Psychiatric Association, 1987
49. Teplin LA, Abram KM, McClelland GM, *et al*: Psychiatric disorders in youth in juvenile detention. *Arch Gen Psychiatry* 59: 1133–43, 2002
50. Bell AS: A critical review of ADHD diagnostic criteria: what to address in the DSM-V. *J Att Disord* 15:3–10, 2011
51. Batstra L, Frances A: DSM-5 further inflates attention deficit hyperactivity disorder. *J Nerv Ment Disease* 200:486–8, 2012
52. Andersen SL, Teicher MH: Sex differences in dopamine receptors and their relevance to ADHD. *Neurosci Biobehav Rev*. 24:137–41, 2000
53. Sibley MH, Pelham WE, Molina BS, *et al*: The delinquency outcomes of boys with ADHD with and without comorbidity. *J Abnorm Child Psychol* 39:21–32, 2011
54. Substance Abuse and Mental Health Services Administration: *Results from the 2002 national survey on drug use and health: national findings*. Rockville, MD: U.S. Department of Health and Human Services Publication SMA 03-3836, 2003
55. McReynolds LS, Schwalbe CS, Wasserman GA: The contribution of psychiatric disorder to juvenile recidivism. *Crim Just & Behav* 37:204–16, 2010
56. Schubert CA, Mulvey EP: *Behavioral health problems, treatment, and outcomes in serious youthful offenders*. Washington, DC: U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention, 2014
57. Winters KC, Martin CS, Chung T: Substance use disorders in DSM-5 when applied to adolescents. *Addiction* 106:882–4, 2011
58. Heilbrun K, Grisso T, Goldstein AM: *Foundations of Forensic Mental Health Assessment* New York: Oxford University Press, 2008
59. Zapf PA, Roesch R: *Evaluation of Competence to Stand Trial*. New York: Oxford University Press; 2009
60. Borum R, Bartel PA, Forth AE: *Structured Assessment of Violence Risk in Youth in Mental Health Screening and Assessment in Juvenile Justice*. New York: Guilford Press; 311–23, 2005
61. Murrie DC, Cornell DG, McCoy WK: Psychopathy, conduct disorder, and stigma: does diagnostic labeling influence juvenile probation officer recommendations? *Law & Hum Behav* 29:323–42, 2005

62. Moffitt TE: Adolescence-limited and life-course-persistent anti-social behavior: a developmental taxonomy. *Psychol Rev* 100:674, 1993
63. Chauhan P, Reppucci ND, Burnette ML: Application and impact of the psychopathy label to juveniles. *Int J Forensic Ment Health* 6:3–14, 2007
64. Jones S, Cauffman E: Juvenile psychopathy and judicial decision making: an empirical analysis of an ethical dilemma. *Behav Sci & L* 26:151–65, 2008
65. Lewis DO, Lewis M, Unger L, et al: Conduct disorder and its synonyms: diagnoses of dubious validity and usefulness. *Am J Psychiatry* 141:514–19, 1984
66. Petrila J, Skeem JL: Juvenile psychopathy: the debate. *Behav Sci & L* 21:689–94, 2003
67. Gretton HM, Hare RD, Catchpole RE: Psychopathy and offending from adolescence to adulthood: a 10-year follow-up. *J Consult Clin Psychol* 72:636–45, 2004