



Child Welfare and Juvenile Justice: Examining the Unique Mental Health Needs of Girls

Robin Lennon-Dearing , Kathryn S. Whitted & Elena Delavega

To cite this article: Robin Lennon-Dearing , Kathryn S. Whitted & Elena Delavega (2013) Child Welfare and Juvenile Justice: Examining the Unique Mental Health Needs of Girls, Journal of Family Social Work, 16:2, 131-147, DOI: [10.1080/10522158.2013.765326](https://doi.org/10.1080/10522158.2013.765326)

To link to this article: <https://doi.org/10.1080/10522158.2013.765326>



Published online: 20 Mar 2013.



Submit your article to this journal [↗](#)



Article views: 576



View related articles [↗](#)

Child Welfare and Juvenile Justice: Examining the Unique Mental Health Needs of Girls

ROBIN LENNON-DEARING, KATHRYN S. WHITTED, and
ELENA DELAVEGA

*Department of Social Work, School of Urban Affairs and Public Policy,
The University of Memphis, Memphis, Tennessee*

This study investigated the prevalence of mental health problems among girls who are involved in child welfare or juvenile justice systems. The sample consisted of 1,193 girls ranging in age from 4 to 18, the majority (82.3%, $n = 982$) of which were older than age 12. Differences based on race/ethnicity and developmental age groups were examined. Consistent with other research, this study found that the mental health needs of girls involved in the child welfare or juvenile justice systems are several times higher than in the general population. Intervention approaches must be developed that take into consideration differences in gender, age, and racial and ethnic group.

KEYWORDS *Strengths and Difficulties Questionnaire (SDQ), girls, mental health, child welfare, juvenile justice*

Mental health is a key component in all children's healthy development, because many, if not most, lifetime psychiatric disorders first appear in childhood or adolescence (Costello, Egger, & Angold, 2005). Early detection and management of girls' mental health disorders are critical for bringing them the supports and treatments they need and help ensure that problems do not worsen nor have negative long-term consequences on their personal development and life potential. If left unrecognized or untreated, mental illnesses that occur in childhood frequently persist into adulthood and may lead to conditions such as greater risk-taking behaviors, low self-esteem, and school failure that can begin a downward spiral of poor outcomes that reduce an

Address correspondence to Robin Lennon-Dearing, PhD, MSW, Assistant Professor, Department of Social Work, School of Urban Affairs and Public Policy, The University of Memphis, 120 McCord Hall, Memphis, TN 38152-3330. E-mail: rlnndrn@memphis.edu

individual's quality of life and ability to meet full potential (Essau, Conrardt, Sasagawa, & Ollendick, 2012). Indeed, research on child and adolescent mental health indicates that no other illness has such damaging effects on children as does mental illness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2002).

According to the report of the Surgeon General on mental health (U.S. Department of Health and Human Services [USDHHS], 1999), childhood psychiatric disorders arise from the complex interactions of a child and her environment and shape each other over the course of development. Specific psychiatric disorders (e.g., autism, attention-deficit/hyperactivity disorder [ADHD], anxiety disorder, etc.) describe impaired emotional, cognitive, physical, and/or behavioral functioning in the context of family, school, community and culture (American Academy of Child and Adolescent Psychiatry [AACAP], 1997). Due to the stigma connected to the terms *psychiatric problems* and *mental illness*, we chose to use the term *mental health needs* in this article to describe social, emotional, and behavioral difficulties as measured by the parent form of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997).

Trauma, Abuse, and the Child Welfare and Juvenile Justice Systems

Although youth initially come to the attention of the child welfare and juvenile justice systems for different reasons, either due to abuse and neglect or because they have committed delinquent acts, they often have similar needs and experiences (Leone & Weinberg, 2010). The majority of youth who enter the child welfare system and many who are involved in the juvenile justice system have experienced abuse and neglect, dysfunctional home environments, destructive and inconsistent parenting practices, poverty, school-related problems, exposure to deviant peers, as well as community and societal problems (Leone & Weinberg, 2010; Wasserman & Seracini, 2001). Youth in the child welfare and juvenile justice systems have high rates of traumatic experiences and are at higher risk for mental health problems than those in the general population. It has been estimated that between 50% and 80% of youth involved in the child welfare system suffer from moderate to severe mental health problems (Burns et al., 2004; Cutajar et al., 2010; King et al., 2011). Among youth involved in the juvenile justice system, the prevalence of mental health problems is estimated to be even higher (Vogel & Messner, 2012; Yampolskaya & Chuang, 2012). Youth coming from the child welfare system into the juvenile justice system are younger and more likely to be female (Ryan, Hertz, Hernandez, & Marshall, 2007). One of the most significant risk factors for girls is prior victimization. Greater percentages of girls than boys are in residential placement for status offenses (e.g., running away from home and truancy) and assaults (Sedlak & Bruce, 2010). Between 1999 and 2008, juvenile arrests for simple assault

decreased 6% for boys but increased 16% for girls (Sedlak & Bruce, 2010). Although overall juvenile crime has decreased in recent years, crimes committed by girls are on the rise (Puzzanchera, 2009). Girls in custody for violent offenses are more likely than boys (82% of girls vs. 67% of males) to report that they know or are related to their victims (e.g., family member or intimate partner; Sedlak & Bruce, 2010).

Girls pose a significant challenge to the juvenile justice system, as they present with a complex set of problems—mental health disorders, histories of childhood abuse and neglect—and treatment needs that differ from boys. Although a significant number of boys and girls who are involved in the juvenile justice systems have experienced trauma, maltreatment, and family discord, a greater percentage of girls have been physically and sexually abused (King et al., 2011). The prevalence of childhood maltreatment among girls in the juvenile justice system far exceeds the prevalence of maltreatment among youths in the general population. A study by King et al. (2011) found that 41% of females reported a history of sexual abuse compared with 13% of females in the general population. Furthermore, among females, sexual abuse was associated with every type of psychiatric disorder. Females who experienced various types of abuse were 2.6 to 10.7 times as likely as females with no history of maltreatment to have any psychiatric disorder (King et al., 2011). Widom (2000) found that girls who have been abused or neglected in childhood were more likely than a comparison control group to attempt suicide, to abuse alcohol or be dependent on it, or to suffer from an antisocial personality disorder.

A number of youth in the child welfare system and the juvenile justice system are placed in residential settings away from their families (Snyder & Sickmund, 2006). When youth are removed from their homes, the move is almost always associated with multiple losses (e.g., family, friends, school, neighborhood, favorite possessions; DePanfilis & Salus, 2003). Many youth also have to cope with numerous moves, which makes it difficult for youth to form and maintain positive relationships with others and can adversely affect their mental health (American Academy of Pediatrics [AAP], 2000; The Center for Human Services, 2008). Furthermore, many of these children experience placement instability, which may exacerbate mental health problems (Rubin, O'Reilly, Luan, & Localio, 2007). It has been well documented that youth who experience multiple placements are more likely to require mental health services for mood, behavior, psychotic, anxiety, and adjustment disorders (Newton, Litrownik, & Landsverk, 2000). Youth with emotional and behavioral problems placed in out-of-home care are less likely than youth without emotional and behavioral problems to find placement stability or permanency and, as a result, are even more vulnerable to continued changes in placement and the related mental health consequences (Park & Ryan, 2009).

Unfortunately, many out-of-home placement facilities are not equipped to meet the serious mental health needs of children and youth. This is

particularly troubling because the consequences of failing to meet these needs can be extreme. Suicide rates in juvenile detention facilities are more than 4 times higher than for adolescents overall. Suicide is even more likely for adolescents confined in isolation (Hayes, 2000). There is also evidence that a youths' mental health problems are made worse when they are exposed to correctional facilities (Holman & Ziedenberg, 2006). To compound matters further, many studies suggest that detention and residential placement settings are particularly damaging to girls (Holman & Ziedenberg, 2006). Girls are often retraumatized once incarcerated. In response to minor rule violations, girls may be subjected to excessive physical force by staff, such as frequent strip searches and the use of forcible restraints, which are physically and mentally scarring (Lewis, 2006).

Similarly, minority youth are over-represented in the child welfare and juvenile justice systems (Rawal, Romansky, Jenuwine, & Lyons, 2004). Although youth of color represent 34% of the nation's population, they account for 67% of youth committed to public institutions. Minority youth are 6 times more likely to be incarcerated than White youth for comparable offenses, and ethnic bias among female juvenile offense cases is evident. Seven of every 10 cases involving White girls are dismissed, compared with only three of every 10 cases involving minority girls (American Bar Association and National Bar Association, 2001). Research suggests that structural racism, public policies, and institutional practices often developed for White youth contribute to inequitable outcomes and are contributing factors to racial disproportionality in the child welfare and juvenile justice systems (Center for the Study of Social Policy, 2009).

PURPOSE

Girls who are involved in the child welfare or juvenile justice systems are truly one of America's most vulnerable populations. This vulnerability is due, in part, to the relationship between child maltreatment and the risk of becoming involved in delinquency (King et al., 2011), as well as the inadequacy of the system to serve the needs of girls and minorities. As a result, girls, in particular minority girls, are revictimized, entering a vicious circle of victimization and negative response. Although a number of policies have been instituted to respond to the unique needs of girls, until recently, few research studies have examined how their needs manifest in terms of social, emotional, and behavioral problems (Moretti, Odgers, Reppucci, & Catherine, 2011). Furthermore, few studies have examined how the needs of minority girls may differ from White girls, and even fewer studies have examined how the mental health problems of very young girls are manifested in terms of social, emotional, and behavioral problems. This study examines the prevalence of social, emotional, and behavioral problems among girls involved in the child welfare or juvenile

justice systems and examines how girls' mental health needs may differ when demographic characteristics such as race and age group comparisons are examined. This study addresses the following three research questions:

1. To what extent do girls involved in the child welfare or juvenile justice systems have social, emotional, or behavioral problems?
2. How do the social, emotional, and behavioral problems of minority and White girls involved in the child welfare or juvenile justice systems differ?
3. How do the social, emotional, and behavioral problems of girls involved in the child welfare or juvenile justice systems differ by age group?

METHOD

Sample

The agency that supplied the data for this study serve youth from 10 states (Alabama, Arkansas, Florida, Georgia, Massachusetts, Mississippi, North Carolina, Tennessee, Texas, Virginia, and the District of Columbia). Referrals come through the child welfare system and the juvenile justice system. The continuum of services includes residential treatment, community-based group homes, foster care, and intensive in-home treatment for children and adolescents with emotional and behavioral problems. Youth may be served in multiple programs.

The data set consisted of 1,193 girls who received behavioral health care services between 2006 and 2010, ranging in age from 4 to 18, the majority (82.3%, $n=982$) of which were older than age 12. Due to lack of race information, 23 (1.9%) were excluded from analyses involving race, and nine (0.8%) were excluded from analyses involving age (see Table 1).

TABLE 1 Frequencies and Percentages in Sample

Girls in sample	<i>n</i>	%
Total	1193	100
White	731	61.3
Minority	439	36.8
Missing race	23	1.9
Younger than age 12	202	16.9
Age 12 and Older	982	82.3
Missing age	9	0.8
Total Girls with Scores in the Borderline or Abnormal Range		
Emotional Symptoms	750	62.9
Conduct Problems	972	81.5
Hyperactivity	677	56.7
Peer Problems	759	63.6
Total Difficulties	909	76.2

Instrument

The SDQ used in this study is a brief behavioral screening questionnaire designed to assess a youth's emotional health, conduct problems, hyperactivity, peer relationship problems, and prosocial behaviors (Goodman, 1997). The scale items were selected based on the diagnostic categories of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*) and International Classification of Diseases, Tenth Revision (ICD-10) (Goodman, Ford, Simmons, Gatward, & Meltzer, 2000).

The questionnaire has several forms: the parent report form, the teacher report, and the self-report form for youth ages 11 to 16. The parent report form was used in this study. The SDQ was administered to parents of youth who entered services during 2006 and 2010. Whenever possible the survey was completed by the child's biological parents. However, when a biological parent was not able to or willing to complete the questionnaire, the questionnaire was completed by the youth's foster parent or case manager. The SDQ has been found to be valid and internally consistent and has been normed on diverse populations (Hill & Hughes, 2007; Palmieri & Smith, 2007; Stone, Otten, Engels, Vermulst, & Janssens, 2010).

The questionnaire consists of 25 items divided between five subscales of five items each: emotional symptoms (e.g., often seems worried, often unhappy, depressed or tearful), conduct problems (e.g., often lies or cheats, often fights with other youth or bullies them), hyperactivity (e.g., constantly fidgeting or squirming, easily distracted, concentration wanders), peer problems (e.g., has at least one good friend, generally liked by other youth), and prosocial behavior (e.g., considerate of other people's feelings, kind to younger children). Questionnaires are available free of charge from the SDQ website: <http://www.sdqinfo.com/>.

Consistent with manual instructions, the first four subscales are added together to obtain the youth's *Total Difficulties score*. Each item is rated on a 3-point scale (0 = *not true*, 1 = *somewhat true*, 3 = *certainly true*). The resultant score can range from 0 to 40. The items on the subscales are scored to generate individual subscale scores. Subscale scores can range from 0 to 10. Higher scores indicate more difficulties in that area. Because this study focuses on mental health needs of girls involved in the child welfare and juvenile justice systems, the prosocial subscale was excluded, as it does not contribute to the analysis. Normative data using parent ratings in an American sample came from the 2001 National Health Interview Survey (Bourdon, Goodman, Rae, Simpson, & Koretz, 2005).

Statistical Analysis

Preliminary descriptive statistics and frequency tables were conducted on the sample to obtain means, standard deviations, and frequencies. To answer

Research Question 1, the researchers compared the results obtained here with normative data.

To answer Research Questions 2 and 3, the researchers conducted *t* test analyses on continuous data and χ^2 analyses on dichotomous data (borderline/normal, per the guidelines provided by the SDQ author). The independent variables were race (White and minority youth) and age group (girls age 4–11 and girls age 12–18) and the five dependent variables were Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems, and Total Difficulties scores. Significance levels for all statistical analyses were preselected to be the level of $p < 0.05$. All data were analyzed in SPSS version 20.0.

RESULTS

Results show the extent of difficulties among the girls in this study, with 76.2% ($n = 909$) of girls obtaining Total Difficulties scores in the borderline or abnormal range (a score of 14 or greater), with a mean score of 18.87 and a standard deviation of 7.30. This mean score is almost 3 times as high as the mean score in the normed sample (see Tables 1 and 2 for results by race and age groups). Results show that 92.8% ($n = 1107$) of the girls had scores in the borderline or abnormal range on at least one subscale, 80.2% ($n = 956$) had scores in the borderline or abnormal range on at least two of the subscales, 60.8% ($n = 725$) had scores in the borderline or abnormal range on at least three of the subscales, and 30.8% ($n = 367$) had scores in the borderline or abnormal range on all four of the subscales. The most frequently observed problem domain was the Conduct Problems subscale, in which more than 81% ($n = 972$) of the girls had scores in the borderline or abnormal range. More than 63% ($n = 759$) of girls in this study were observed to have high levels of Peer Problems (scores in the borderline or abnormal range) and more than 62% ($n = 750$) of the girls were observed to have Emotional Symptoms in the borderline or abnormal range (a score of 4 or higher). In addition, more than 56% ($n = 677$) of the youth had scores that were in the borderline or abnormal range on the Hyperactivity subscale (a score of 6 or higher). Means and standard deviations for the SDQ total scale and subscale scores by race and age groups are reported in Table 2, which also reports and compares the SDQ total scale and subscale scores with American normative data of girls ages 4 to 17, showing that this sample has higher scores.

Results of the χ^2 analysis (see Table 3) show significant results in terms of differences by race in the Emotional Symptoms subscale ($\chi^2 = 31.281$, $df = 1$, $p = .000$), on the Conduct Problems subscale ($\chi^2 = 14.953$, $df = 1$, $p = .000$), and on the Total Difficulties scale ($\chi^2 = 10.934$, $df = 1$, $p = .001$). White girls exhibited higher percentages of problematic scores than minority girls.

TABLE 2 Subscale and Total Strengths and Difficulties Questionnaire Mean Scores (Standard Deviations) and Comparisons by Race and Age Group

	Subscales of SDQ				Total Difficulties score
	Emotional	Conduct	Hyperactivity	Peer Problems	
Cut point (Borderline – Abnormal) Normed data	4–10	3–10	6–10	3–10	14–40
U.S. girls in community ages 4–18	1.7 (1.9)	1.2 (1.5)	2.4 (2.3)	1.3 (1.5)	6.6 (5.5)
Race of study sample <i>t</i> test	6.291***	1.167	4.958***	0.642	4.678***
White (<i>n</i> = 731)	4.88 (2.57)	5.13 (2.69)	6.28 (2.60)	3.41 (2.14)	19.71 (7.28)
Minority (<i>n</i> = 439)	3.91 (2.56)	4.94 (2.58)	5.51 (2.58)	3.33 (1.97)	17.66 (7.16)
Age groups in sample <i>t</i> test	-0.842	-0.215	3.256**	0.438	0.843
Younger than age 12 (<i>n</i> = 202)	4.36 (2.56)	5.02 (2.91)	6.57 (2.89)	3.43 (2.11)	19.34 (8.44)
Age 12 years and older (<i>n</i> = 982)	4.53 (2.62)	5.07 (2.60)	5.86 (2.53)	3.36 (2.07)	18.80 (7.05)

Note. Higher scores on subscales indicate greater difficulties.

***p* significant <0.01 level. ***significant at the <0.000 level.

The results of the χ^2 analyses (see Table 3) show significant results in terms of differences by age group only on the Hyperactivity scale ($\chi^2=7.243$, $df=1$, $p=.000$). Younger girls (65.3%, $n=132$) exhibited hyperactivity more

TABLE 3 Borderline or Abnormal Scores by Race and Age Group

Strengths and Difficulties Questionnaire subscales and total scale		Race		Age	
		White	Minority	Younger than 12	Age 12 and Older
Emotional Difficulties	<i>n</i>	507	233	127	617
	%	69.4	53.1	60.92	63.2
	χ^2	31.281***		0.395	
Conduct Problems	<i>n</i>	595	358	155	811
	%	81.4	81.5	76.7	82.6
	χ^2	0.004		3.822++	
Hyperactivity	<i>n</i>	499	219	132	540
	%	61.4	50	65.3	55
	χ^2	14.593***		7.243**	
Peer Problems	<i>n</i>	467	278	131	621
	%	63.9	63.3	64.9	63.2
	χ^2	0.037		0.188	
Total Difficulties Scale	<i>n</i>	583	313	149	754
	%	79.8	71.3	73	76.8
	χ^2	10.934**		0.844	

++*p* close to significance at 0.051. ***p* significant at the <0.01 level. ***significant at the <0.000 level.

than older girls (55%, $n = 540$). The Conduct Problems subscale results are tantalizingly close to significance ($\chi^2 = 3.822$, $df = 1$, $p = .051$) with the younger girls (76%, $n = 155$) exhibiting relatively fewer conduct problems than the older girls (82.6%, $n = 811$). However, it is important to note that the Hyperactivity and Conduct Problems subscales are moderately correlated ($r = .569$, $p = .000$).

Results of the t tests (see Table 2) confirm the findings of the χ^2 with significant results in terms of age on the Hyperactivity subscale ($t = 3.256$, $p = .001$) and significant results in terms of race on the Emotional Symptoms ($t = 6.291$, $p = .000$) and Hyperactivity ($t = 4.958$, $p = .000$) subscales and on the Total Difficulties scale ($t = 4.678$, $p = .000$).

DISCUSSION

Extent of Problems

Returning to this study's first question and consistent with other research, this study found that SDQ scores of girls involved in the child welfare or juvenile justice systems are much higher than the scores obtained by the general population. Whereas it has been estimated that about 10% of the general population of children have SDQ scores in the abnormal range, indicative of substantial risk for probable psychiatric problems, this study found that upon admission to agency, more than 76% of the girls in this sample had total difficulties scores that were in the borderline or abnormal range, classified as substantial risk for possible/probable psychiatric problems. Examining the SDQ subscale scores gives a more precise picture of the mental health needs the girls in this study presented. The results of this study suggest there is a substantial risk for possible/probable psychiatric problems among this population of girls.

The high rate of conduct problems among the girls in this study is troubling, yet not unexpected, because all of the girls in this study had been referred for behavioral health services either through the juvenile justice system or the child welfare system. That fact notwithstanding, it is critical that the conduct problems exhibited by girls are examined in context. Risk-taking behaviors among girls is a common reaction to sexual and physical abuse, and the rate of abuse is especially high among girls involved in the child welfare and juvenile justice systems (Wiig, Widom, & Tuell, 2003). The results of this study suggest that this area merits further research.

This study also points to the extraordinary high rates of ADHD symptoms among these girls. Although a number of earlier studies found that boys are far more likely to be diagnosed as having ADHD than girls, a more recent study pointed to the increasing rates of ADHD diagnosis among girls (Robinson, Skaer, Sclar, & Galin, 2002). Briscoe-Smith and Hinshaw (2006) found girls with ADHD were at increased risk of having abuse histories, peer

rejection, and more aggressive behavior than were the nonabused girls. For girls with ADHD and abuse histories, the abuse trauma must be addressed to prevent the symptoms progressing as the girl develops. Additional research is needed to examine the etiology of ADHD to better understand how hyperactivity symptoms differ in girls that have come into the child welfare and/or juvenile justice systems and what treatment approaches may be best with this population.

It is also worth emphasizing that 63% of the girls in this study were reported to have difficulties with peer relations. Youth who have been abused and neglected by caretakers often do not form secure attachments to them, and these early attachment difficulties can lead to later difficulties in relationships with peers (Morrison, Frank, Holland, & Kates, 1999). These findings are alarming because a number of studies have pointed to the relationship between peer problems and later delinquency (see Loeber, Farrington, & Petechuk, 2003). A central unifying factor in women's development theories is the role of relationships and the ability to form and maintain relationships with others is linked to good mental health functioning (Miller & Stiver, 1997). These findings suggest that professionals who work with girls need to be particularly cognizant of assessing and addressing problems in peer relationships.

Racial Differences

The study's second question addressed differences between minority girls and White girls' social, emotional, and behavioral problems as measured by the parent form of the SDQ. In this study, on admission to program services, White girls had significantly higher mean scores on the total difficulties scale, the emotional problems subscale, and the hyperactivity subscale. This finding was unexpected because prior research indicates no significant differences in prevalence between racial/ethnic groups of child mental health problems in either urban or rural communities (Howell & McFeeters, 2008).

Racial disparities do exist in the disproportionate representation of minority children in the child welfare system and the juvenile justice system (Chapin Hall Center for Children, 2008). There is disproportionate minority contact with both systems, with disparities existing at almost all decision points. Although in the child welfare system, minority youth are twice as likely as White youth to become known to the juvenile justice system (Herz & Ryan, 2008). Minority youth are more likely to be removed from their homes by the juvenile justice system than White youth who exhibit similar behavior problems, whereas White families are more likely to receive services that allow the children to remain in the home (Derezotes & Poertner, 2005; Poe-Yamagata & Jones, 2000; Pope, Lovell, & Hsia, 2002). Our results seem to support the idea that White girls with problems in the lower range are not being institutionalized, whereas minority girls are institutionalized with problems at levels that warrant home services.

These disparities suggest that minority female youth involved in the child welfare and juvenile justice systems may be especially at risk for developing more chronic and severe social, emotional, and behavioral difficulties. Based on the results of this study, the authors suggest that a follow-up longitudinal study of the mental health needs of girls in the child welfare and juvenile justice systems where the different trajectories of girls of different races is needed to shed light on the long-term consequences on the emotional and mental health of girls in state care. The researchers also suggest the need to conduct a similar study examining the health and mental health needs of girls in the community for comparison purposes.

Age Group Differences

This study's third question looked at differences by age group of girls' social, emotional, and behavioral problems as measured by the parent form of the SDQ. Results indicate that the behavioral, social and emotional needs of pre-adolescent girls between ages 4 and 11 are particularly high. The younger girls in this study had similar levels of difficulty in three of the four subscales (Emotional Symptoms, Conduct Problems, and Peer Problems) and the total difficulties score as their adolescent peers, and higher mean scores on the hyperactivity subscale. The high rates of social, emotional, and behavioral problems among children in the younger age group are especially troubling because early onset of conduct disorder, hyperactivity, and peer problems has been associated with early child delinquency. Youth who begin delinquent behaviors prior to age 13 are at much higher risk of becoming serious, violent, and chronic juvenile offenders (Loeber et al., 2003). Furthermore, many mental health disorders begin in early childhood and persist into adulthood and cause lifelong distress and disability (Kessler et al., 2005).

The finding of high scores on the SDQ hyperactivity subscale for pre-adolescent and adolescent girls is a sobering statistic indeed. ADHD along with childhood maltreatment may increase the risk for later substance use disorders (De Sanctis et al., 2008). In a sample of adolescents with a history of childhood ADHD, De Sanctis and colleagues (2008) found those who were maltreated reported substance use disorders rates of 55% compared to rates of 13% in the general population.

The high prevalence of hyperactivity in this population also suggests that children who may benefit from treatment may not be receiving it and are instead being turned to the juvenile justice and child welfare systems. This is disturbing and suggests that punitive action rather than treatment is being used against these girls.

Limitations

Although this study included a large sample of youth from 10 different states, several limitations should be noted. First, this study used only the parent

report version of the SDQ. Strengths and difficulties were based on parental reports (or if necessary, the youth's foster parent or case manager). This may cause some bias in the reported results. It is possible that the youths' parents over-reported or under-reported their children's social, emotional, or behavioral difficulties. However, previous research using the SDQ has indicated relatively strong reliability and validity of the parent report version of this instrument (Goodman, 2001).

Second, the participants in this study consisted of youth who were referred for behavioral health services and who were referred through the child welfare and the juvenile justice systems. Because many of the girls were involved in the juvenile justice and the child welfare systems, and many youth transition between these two systems, the agency was not able to provide data that would allow for the analysis of these two groups independently. Therefore, it was not possible to separate these two groups and analyze the data based on the specific service delivery system. However, because many of the girls involved in this study transition between the juvenile justice and the child welfare system and the characteristics and the needs of these girls are similar, this type of analysis was not deemed imperative to the purposes of this study.

Third, this study consisted of girls who were receiving services in therapeutic foster care homes, residential treatment facilities, group homes, and in-home treatment services. There was no attempt to examine the behavioral or social emotional differences that likely existed among girls who received services while residing in the different types of treatment programs. The findings in this study are not reflective of the general population, and efforts to make generalizations to girls receiving services through other behavioral health agencies should be carefully considered.

Finally, this study did not consider the social history of the girls, such as demographic information about the girls' family of origin (marital status of the biological parents, socioeconomic status of the biological parents, whether the biological parents had legal custody), or information about the family's previous use of social or welfare services (e.g., foster care, mental health services). Because a substantial body of research demonstrates that cumulative risk factors are correlated with social, emotional and behavioral functioning (Messina & Grella, 2006), it is likely that the girls who had a number of high-risk factors would likely have higher scores on the SDQ. However, no statistical analysis was employed to test these assumptions.

IMPLICATIONS AND RECOMMENDATIONS

The mental health needs of girls must be assessed and approached in a sensitive, caring manner, and effective interventions must target the emotional, social, and behavioral reactions to abuse. The findings of this study point to

the need of further research, in particular longitudinal research that examines the developmental trends of difficulties and mental health issues in girls involved in the child welfare and juvenile justice systems. It is important to examine differential developmental trajectories for minority and White girls as they age in the system and to explore the etiology and possible contributing factors to these differences. If differences exist, are differences due to developmental factors, or are the differences the result of differential treatment and intervention experiences?

Because girls internalize the consequences of abuse, leading in extreme cases to schizophrenia and a number of persistent mental illnesses (Cutajar et al., 2010; Gilbert et al., 2009), the long-term consequences of abuse are troubling not only for the girls themselves, but also to future generations. Unaddressed mental health issues in girls may have long-term and profound consequences in the intergenerational transmission of abuse, oppression, marginalization, and poverty. As society, it behooves us to help girls overcome their mental health issues to promote social and economic development and the break the cycle of poverty. Because of racial disparities in outcomes, it is important to develop interventions that are sensitive not only to gender, but also to race and culture as well.

Policies that promote mental health of children in the child welfare and/or juvenile justice systems must be developed that specifically address the needs of girls. The results of this study indicate that girls that enter either system have a much higher prevalence of problems and unmet mental health needs than the general population, and as a result, are at much higher risk for a host of problems in the future. Addressing the mental health of needs of girls as they enter the system has the potential for preventing further suffering on the part of the girls, and lower long term costs to society. Policy and policy makers need to recognize the special needs of girls in the child welfare and social justice systems and develop policy accordingly. The results of this study suggest that structural racism may be playing a part in the provision of services to girls of color. Minority girls may not be receiving the necessary services in the community, and as a result end up in the juvenile justice or child welfare systems sooner and presenting lower levels of problems than Caucasian girls.

CONCLUSION

This article expands the knowledge base regarding the emotional and behavioral needs of girls receiving services in the child welfare and juvenile justice systems. It confirms a high rate of risk for social, emotional, and behavioral difficulties. Actively pursuing needed services that are gender sensitive and also take into consideration the unique needs of youth of different racial and ethnic groups and among girls in different developmental age groups may

prevent future costs associated with juvenile and criminal activity, mental illness, substance abuse, and domestic violence. Future research needs to examine factors that contribute to favorable treatment outcomes for girls and promote their ability to be successful in educational settings, peer relationships, and family functioning.

REFERENCES

- American Academy of Child and Adolescent Psychiatry. (1997). Practice parameters for the psychiatric assessment of children and adolescents. *Journal of American Academy of Child and Adolescent Psychiatry*, 36(10 Suppl.), 4S–20S.
- American Academy of Pediatrics. (2000). Developmental issues for young children in foster care. *Pediatrics*, 106, 1145–1150.
- American Bar Association and National Bar Association. (2001). *Justice by gender: The lack of appropriate prevention, diversion and treatment alternatives for girls in the justice system*. Washington, DC: Author.
- Bourdon, K. H., Goodman, R., Rae, D. S., Simpson, G., & Koretz, D. S. (2005). The Strengths and Difficulties Questionnaire: U.S. normative data and psychometric properties. *Journal of the American Academy of Adolescent Psychiatry*, 44(6), 557–564.
- Briscoe-Smith, A. M., & Hinshaw, S. P. (2006). Linkages between child abuse and attention deficit hyperactivity disorder in girls: Behavioral and social correlates. *Child Abuse and Neglect*, 30(11), 1239–1255.
- Burns, B., Phillips, S., Wagner, H., Barth, R., Kolko, D., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(8), 960–970.
- Center for Human Services. (2008). *Placement stability in child welfare services issues, concerns, outcomes and future directions literature review*. Davis: University of California, Davis, Extension, Northern California Training Academy. Retrieved from <http://www.dss.cahwnet.gov/cfsweb/res/pdf/PlacementStability.pdf>
- Center for the Study of Social Policy. (2009). *Race equity review: Findings from a qualitative analysis of racial disproportionality and disparity for African American children and families in Michigan's Child Welfare System*. Retrieved from <http://www.cssp.org/publications/child-welfare/institutional-analysis/race-equity-review-findings-from-a-qualitative-analysis-of-racial-disproportionality-and-disparity-for-african-american-children-and-families-in-michigans-child-welfare-system.pdf>
- Chapin Hall Center for Children. (2008). *Understanding racial and ethnic disparity in child welfare and juvenile justice*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago. Retrieved from http://cjr.georgetown.edu/pdfs/cjir_ch_final.pdf
- Costello, E. J., Egger, H., & Angold, A. (2005). 10-year research update review: The epidemiology of child and adolescent psychiatric disorders: I. Methods and public health burden. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44(10), 972–986.

- Cutajar, M. C., Mullen, P. E., Ogloff, J. R. P., Thomas, S. D., Wells, D. L., & Spataro, J. (2010). Schizophrenic and other psychotic disorders in a cohort of sexually abused children. *Archives of General Psychiatry*, *67*(11), 1114–1119.
- DePanfilis, D., & Salus, M. K. (2003). *Child Protective Services: A guide for caseworkers*. Washington, DC: Administration for Children and Families. Retrieved from <http://www.childwelfare.gov/pubs/usermanuals/cps/cpsf.cfm>
- Derezotes, D. M., & Poertner, J. (2005). Factors contributing to the overrepresentation of African American children in the child welfare system. In D. M. Derezotes, J. Poertner, & M. F. Testa (Eds.), *Race matters in child welfare: The overrepresentation of African American children in the system* (pp. 1–23). Washington, DC: Child Welfare League of America.
- De Sanctis, V. A., Trampush, J. W., Marks, D. J., Miller, C. J., Harty, S. C., Newcorn, J. H., & Halperin, J. M. (2008). Childhood maltreatment and conduct disorder: Independent predictors of adolescent substance use disorders in youth with ADHD. *Journal of Clinical Child Adolescent Psychology*, *37*(4), 785–793.
- Essau, C. A., Conradt, J., Sasagawa, S., & Ollendick, T. H. (2012). Prevention of anxiety symptoms in children: Results from a universal school-based trial. *Behavior Therapy*, *43*(2), 450–464.
- Gilbert, R., Widom, K. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet*, *373*(9657), 68–81.
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, *38*, 581–586.
- Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*(11), 1337–1345.
- Goodman, R., Ford, T., Simmons, H., Gatward, R., & Meltzer, H. (2000). Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *British Journal of Psychiatry*, *177*, 534–539.
- Hayes, L. M. (2000). Suicide prevention in juvenile facilities. *Juvenile Justice*, *7*(1), 24–32.
- Herz, D., & Ryan, J. P. (2008). *Building multisystem approaches in child welfare and juvenile justice*. Washington, DC: Center for Juvenile Justice Reform. Retrieved from <http://cjjr.georgetown.edu/pdfs/wingspreadpart3.pdf>
- Hill, C. R., & Hughes, J. N. (2007). An examination of the convergent and discriminant validity of the Strengths and Difficulties Questionnaire. *School Psychology Quarterly*, *22*(3), 380–406.
- Holman, B., & Ziedenberg, J. (2006). *The dangers of detention: The impact of incarcerating youth in detention and other secure facilities*. Washington, DC: Justice Policy Institute. Retrieved from http://www.cfji.org/pdfs/116-JPI008-DOD_Report.pdf
- Howell, E., & McFeeters, J. (2008). Children's mental health care: Differences by race/ethnicity in urban/rural areas. *Journal of Health Care for the Poor and Underserved*, *19*(1), 237–247.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*, 593–602.

- King, D. C., Abram, K. M., Romero, E. G., Washburn, J. J., Welty, L. J., & Teplin, L. A. (2011). Childhood maltreatment and psychiatric disorders among detained youths. *Psychiatric Services, 62*(12), 1430–1438.
- Leone, P., & Weinberg, L. (2010). *Addressing the unmet educational needs of children and youth in the juvenile justice and child welfare systems*. Washington, DC: Center for Juvenile Justice Reform, Georgetown University. Retrieved from <http://cjjr.georgetown.edu/pdfs/ed/edpaper.pdf>
- Lewis, M. (2006). *Custody and control: Conditions of confinement in New York's juvenile prisons for girls*. New York, NY: American Civil Liberties Union and Human Rights Watch. Retrieved from <http://www.hrw.org/en/reports/2006/09/24/custody-and-control>
- Loeber, D., Farrington, D. P., & Petechuk, D. (2003). *Child delinquency: Early intervention and prevention bulletin*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Retrieved from <http://www.ncjrs.gov/pdffiles1/ojjdp/186162.pdf>
- Messina, N., & Grella, C. (2006). Childhood trauma and women's health: A California prison population. *American Journal of Public Health, 96*, 1842–1848.
- Miller, J. B., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life*. Boston, MA: Beacon Press
- Moretti, M. M., Odgers, C., Reppucci, N. D., & Catherine, N. L. A. (2011). Serious conduct problems among girls at risk: Translating research into intervention. *International Journal of Child, Youth, & Family Studies 2*(1/2), 142–161.
- Morrison, J. A., Frank, S. J., Holland, C. C., & Kates, W. R. (1999). Emotional development and disorders in young children in the child welfare system. In J. A. Silver, B. J. Amster, & T. Haecker (Eds.), *Young children and foster care: A guide for professionals* (pp. 33–64). Baltimore, MD: Paul H. Brookes.
- Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect, 24*(10), 1363–1374.
- Palmieri, P. A., & Smith, G. C. (2007). Examining the structural validity of the Strengths and Difficulties Questionnaire (SDQ) in a U.S. sample of custodial grandmothers. *Psychological Assessment, 19*(2), 189–198.
- Park, J. M., & Ryan, J. P. (2009). Placement and permanency outcomes for children in out-of-home care by prior inpatient mental health treatment. *Research on Social Work Practice, 19*(1), 42–51.
- Poe-Yamagata, E., & Jones, M. (2000). *And justice for some: Differential treatment of minority youth in the justice system*. Washington, DC: Building Blocks for Youth. Retrieved from <http://www.cclp.org/documents/BBY/jfs.pdf>
- Pope, C., Lovell, R., & Hsia, H. (2002). *Disproportionate minority confinement: A review of the research literature from 1989 through 2001*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Retrieved from http://www.ojjdp.gov/dmc/pdf/dmc89_01.pdf
- Puzzanchera, C. (2009, December). Juvenile arrests 2008. *Juvenile Justice Bulletin*. Retrieved from <http://www.ncjrs.gov/pdffiles1/ojjdp/228479.pdf>
- Rawal, P., Romansky, J., Jenuwine, M., & Lyons, J. S. (2004). Racial differences in the mental health needs and service utilization of youth in the juvenile justice system. *Journal of Behavioral Health Services Research, 31*(3), 242–254.

- Robinson, L. M., Skaer, T. L., Sclar, D. A., & Galin, R. S. (2002). Is attention deficit hyperactivity disorder increasing among girls in the US? Trends in diagnosis and the prescribing of stimulants. *CNS Drugs*, *16*(2), 129–145.
- Rubin, D. M., O'Reilly, A. L. R., Luan, X. Q., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*, *119*(2), 336–344.
- Ryan, J. P., Herz, D., Hernandez, P., & Marshall, J. (2007). Maltreatment and delinquency: Investigating child welfare bias in juvenile justice processing. *Children and Youth Services Review*, *29*, 1035–1050.
- Sedlak, A. J., & Bruce, C. (2010, December). Youth's characteristics and backgrounds: Findings from the survey of youth in residential placement. *Juvenile Justice Bulletin*. Retrieved from <http://www.ncjrs.gov/pdffiles1/ojdp/227730.pdf>
- Snyder, H., & Sickmund, M. (2006). *Juvenile offender and victims: A national report*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Retrieved from <http://www.ojdp.gov/ojstatbb/nr2006/downloads/NR2006.pdf>
- Stone, L. L., Otten, R., Engels, R. M., Vermulst, A. A., & Janssens, J. M. (2010). Psychometric properties for the parent and teacher version of the Strengths and Difficulties Questionnaire for 4–12 year-olds: A review. *Clinical Child and Family Psychology Review*, *13*(3), 254–274.
- Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders*. Bethesda, MD: Author. Retrieved from <http://www.samhsa.gov/reports/congress2002/CoOccurringRpt.pdf>
- U.S. Department of Health and Human Services, Office of the Surgeon General. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from <http://www.surgeongeneral.gov/library/mentalhealth/home.html>
- Vogel, M., & Messner, S. F. (2012). Social correlates of delinquency for youth in need of mental health services: Examining the scope conditions of criminological theories. *Justice Quarterly*, *29*(4), 546–572.
- Wasserman, G., & Seracini, A. (2001). Family risk factors and interventions. In R. Loeber & D. Farrington (Eds.), *Child delinquents: Development, intervention, and service needs* (pp. 165–189). Thousand Oaks, CA: Sage.
- Widom, C. S. (2000). Childhood victimization: Early adversity, later psychopathology. *National Institute of Justice Journal*, *242*, 2–9.
- Wiig, J., Widom, C. S., & Tuell, J. (2003). *Understanding child maltreatment and juvenile delinquency: From research to effective program, practice, and systemic solutions*. Washington, DC: Child Welfare League of America. Retrieved from <http://www.cwla.org/programs/juvenilejustice/ucmjd.htm>
- Yampolskaya, S., & Chuang, E. (2012). Effects of mental health disorders of the risk of juvenile justice system involvement and recidivism among children placed in out-of-home care. *American Journal of Orthopsychiatry*, *82*(4), 585–593.