

RESEARCH ARTICLE

A Narrative Review on Juvenile Offense and the Impact and Implications of Internalizing Disorders

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ABSTRACT

Youth involved in the juvenile justice system carry a significant burden of mental health challenges. Internalizing disorders such as depression, anxiety, posttraumatic stress disorder, self-harm, and suicidal behavior are common among justice-involved youth, but often remain overlooked. These conditions influence behavior, increase vulnerability to offending, and heighten the risk of repeated involvement with the juvenile justice system. This review examines the role of internalizing disorders in juvenile offense, and highlights how inward distress can contribute to outward behavioral disturbances. It brings together evidence from multiple countries and shows that untreated internalizing symptoms are linked to higher rates of reoffending, adverse life outcomes, and increased suicide risk. The review also summarizes interventions that address mental health needs among justice-involved youth, including cognitive behavioral therapy, family-based approaches, mindfulness practices, and mentoring models. These interventions show promise for symptom reduction, emotional regulation, and lowering recidivism. The review places special focus on Low- and Middle Income Countries where limited resources, stigma, and gaps in mental health services create major barriers to care. Overall, the findings point to the need for prevention, early recognition and intervention for internalizing disorders within juvenile justice systems.

1 | Background

Juveniles are vulnerable to conflict with the law, with late adolescence having the highest rate of involvement with the criminal justice system. In developmental and criminological literature, the terms “adolescent,” “youth,” and “juvenile” are not identical and carry different connotations. “Adolescent” is a developmental and clinical term describing the period between childhood and adulthood, typically ages 10 to 19 (WHO 2023). “Juvenile” is a legal and administrative term referring to individuals who come under the jurisdiction of the juvenile justice system; in most countries this applies to persons below 18 years. “Youth” is the broadest of the three and is used in policy and international frameworks to refer to persons aged 15 to 24 (United Nations 2013). Significantly, one of the most reliable

indicators of adult criminality is juvenile justice involvement; the earlier age of onset, the higher the likelihood of a more serious and persistent criminal path (Moffitt 1993; Tonry and Office of Justice Programs 2003). In the treatment of justice-involved youth, juvenile justice systems have historically alternated between rehabilitative and punitive models. In the United States, for example, following the landmark Supreme Court ruling *In re Gault*, justice-involved youth were given constitutional rights and juvenile justice systems began to operate within medicalization-based, rehabilitative frameworks. However a subsequent spike in violent crime in the late 1980s and early 1990s prompted a tougher, criminalization-based approach in order to protect the community (Fried and Reppucci 2001; Jenson et al. 2001). While juvenile crime decreased as a result,

reoffending or recidivism was found to increase (Office of Juvenile Justice and Delinquency Prevention 2025). Research in this population established adverse mental health conditions as predictors of recidivism. One important explanation was that punitive approaches focused on confinement and severe sentencing were detrimental to the mental health of juveniles at a crucial stage of their development, impeded their ability to engage in reformatory programming, and perpetuated reoffense (Office of Juvenile Justice and Delinquency Prevention 2025).

The failure of punitive, confinement-based approaches to curb recidivism, as well as research linking mental health and psychosocial factors to juvenile justice involvement have turned the focus back to the rehabilitative model with the goal to promote early intervention in these domains, and reduce recidivism. Within the realm of mental health, previous research on justice-involved youth has traditionally focused on externalizing behaviors stemming from aggression and impulsivity, including attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), and oppositional defiant disorder (ODD). Multiple research suggests that the presence of externalizing disorders predict future involvement with the juvenile justice system as well as recidivism. By contrast, substance use disorders have been found to be linked to recidivism and increasing severity of reoffense, rather than first-time involvement (Schubert et al. 2011; Hoeve et al. 2013; McReynolds et al. 2010).

In terms of sex differences, Jun et al. 2015 found that males exhibited a higher correlation between externalizing symptoms and drinking at age 18, while females showed an association between internalizing symptoms and drinking at age 12.

Internalizing disorders are mental health conditions where distress is directed inward, and are equally significant in the juvenile justice context, but understudied. These disorders include depression, anxiety, post-traumatic stress disorder (PTSD), non-suicidal self harm, suicidal behavior, and low self-esteem. A bibliometric analysis on mental health in juvenile justice found that approximately 70% of studies in this area focused exclusively on externalizing disorders (conduct disorder, ADHD, substance use), while less than 20% examined internalizing symptoms as a primary outcome (Shufelt and Coccozza 2006). A subsequent global scoping review found that depression and anxiety in detained youth were addressed in far fewer studies than disruptive behavior disorders (Borschmann et al. 2020). Understanding the role of internalizing disorders in justice-involved youth is critical for early intervention and prevention of recidivism. By focusing on internalizing disorders in this review, we aim to illuminate the often overlooked yet critical mental health challenges that justice-involved youth face in the internalizing domain. Addressing these conditions is essential for developing effective rehabilitation programs that not only reduce recidivism but also improve long-term psychological and social outcomes.

In addition to the above domains, we also focus on the cognitive domain which is another understudied though relevant area. There is mounting evidence that cognitive disorders are associated with severe criminal activity (Ishikawa and Raine 2003). Studies have shown a link between neurodevelopmental deficits

in the prefrontal cortex and antisocial behavior in adolescents, with additional indirect influences from social and environmental risk factors.

2 | Methods

2.1 | Search Strategy

PubMed, PsycINFO, and Scopus were searched using the following terms: “juvenile justice” OR “juvenile detention” OR “juvenile offender” OR “youth offending” AND “internalizing disorder” OR “depression” OR “anxiety” OR “PTSD” OR “self-harm” OR “non-suicidal self-injury” OR “suicidal behavior.” No date restriction was applied, as foundational studies in this area date from the 1980s onwards, and temporal trends in prevalence and intervention efficacy were considered important to capture.

2.2 | Inclusion Criteria

Peer-reviewed original research, systematic reviews, and meta-analyses published in English, examining mental health outcomes among individuals under the age of 18 years who were involved with the juvenile justice system (arrested, detained, adjudicated, or incarcerated). Gray literature from governmental and international bodies (WHO, OJJDP, UNICEF) was included where referenced in existing reviews.

2.3 | Exclusion Criteria

Studies exclusively focused on adult correctional populations, studies in which justice-involved youth were not clearly identified as a distinct subgroup, and single-case reports.

2.4 | Synthesis Approach

This review is a narrative review. Given the breadth and heterogeneity of the literature on juvenile offending and the impact and implications of internalizing disorders, a narrative review was the most appropriate approach to synthesize evidence across diverse study designs, populations, and contexts, and to allow for a thematic and conceptual discussion of the field. A formal Risk of Bias assessment was not conducted, as this is a narrative rather than a systematic review. However, study quality concerns are noted where relevant throughout the text. The limitations of cross-sectional designs (inability to establish temporal precedence), the risk of selection bias in facility-based samples, and the lack of standardized diagnostic instruments across international studies are discussed in the limitations section. The narrative was organized thematically by disorder type, with cross-cutting considerations (sex differences, LMIC contexts, co-occurring disorders) integrated throughout.

3 | Mental Health and Juvenile Offending

To efficiently deploy mental health care, juvenile justice systems must be able to anticipate the proportion of juveniles who have or may develop a mental disorder. Studies show that almost 50 to 75% of youth entering juvenile justice detention centers meet criteria for at least one mental health disorder (Underwood and Washington 2016). Even after 15 years post-detention, two-thirds of males and more than one-third of females experience at least one mental disorder. A mean prevalence of any psychiatric

disease among incarcerated male adolescents was found to be about 70%, according to a systematic analysis (Colins et al. 2012). Girls in the juvenile justice system are at significantly higher risk than boys for meeting criteria for a mental health disorder, with rates of approximately 80% versus 67% respectively, and girls consistently demonstrate higher rates of internalizing disorders specifically (Murie et al. 2026). Young female adolescents entering custody were found to have significantly higher rates of mental illness compared to males across most mental disorder categories, including anxiety disorders, depressive disorder, and PTSD. With respect to PTSD specifically, rates of PTSD among justice-involved youth have been recorded at 8.6% in males and 18.2% in females, with current major depressive episodes affecting approximately 61.7% of males and 59.0% of females (Office of Juvenile Justice and Delinquency Prevention 2025).

Early life adversity and poor adolescent mental health are more pronounced among young people who have early contact with the youth justice system compared to those with late contact, pointing to the need for investment in early support. Once involved, internalizing symptoms may worsen through the iatrogenic effects of detention itself (Malvaso et al. 2022). Longitudinal data from over 5600 justice-involved youth across a 10-year period found that increases in trauma exposure were associated with increasing depression, anxiety, somatic complaints, and suicidal ideation across repeat admissions to detention, with all internalizing outcomes following a trajectory of worsening over multiple admissions (Kerig et al. 2025). This is consistent with evidence that incarceration during adolescence leads to poorer health in adulthood, exacerbating serious pre-existing mental health problems such as depression, PTSD, and suicidal ideation (The Sentencing Project 2023).

The composition of mental health problems is also pertinent for the purposes of prognosis and intervention. Based on a longitudinal study, dysfunctions linked to juvenile justice involvement were broadly classified as externalizing (causing problems primarily directed outward, like conduct issues or aggression) or internalizing (causing problems mainly directed inward, regarding the person's functioning, like anxiety or depression) (Krueger et al. 1998; Loeber and Burke 2011). Developmental criminology places great emphasis on the study of externalizing behaviors such as violence and antisociality (Boers et al. 2010). The characteristics that increase the likelihood of juvenile offense include learning difficulties (Polier et al. 2012), low academic performance (Pardini and Fite 2010), difficulties forming relationships with peers (Dodge et al. 2003; Polier et al. 2012), and social rejection (Bagwell et al. 2001).

A 15-year longitudinal study reported that behavioral disorders such as oppositional defiant disorder (ODD), conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD), as well as substance use disorder were the most prevalent 5 years post-detention, followed by mood, and anxiety disorders (Teplin et al. 2021). Disorders such as Post Traumatic Stress Disorder (PTSD), and antisocial personality disorder (ASPD) also had a higher prevalence when compared with the general population. There are sex differences in the composition of mental health problems among justice-involved youth. Longitudinal data from a nationally representative sample of female juvenile offenders from the first five waves of the National Youth Survey (Gorman-

Smith and Loeber 2005). It was found that ' externalizing behavior and involvement in offending were found to follow similar developmental trends as those of males. Moreover, 70% of the females involved, followed most of the pathways that had been determined to be appropriate for males. In a sample of justice-involved youth 9 months post-incarceration, the prevalence of major externalizing problems such as CD and ODD was not significantly different between the male and female sexes, but females were much more likely to have internalizing disorders like depression (8% males vs. 29% females) and anxiety (26% males vs. 55% females) (Karnik et al. 2009).

A growth mixture model (Reinke et al. 2012) has shown that there is a higher than expected correlation between internalizing and externalizing difficulties. This has given rise to several theories regarding the possible relationships between these types of problems. However, a lot of this assumption is based on data gathered during late childhood or adolescence, which may have led to an over-emphasis on underlying issues that become more apparent later in development rather than in early childhood. Adolescents' perception of time and future consequences is governed by still-maturing prefrontal cortical systems, particularly those involved in future-oriented thinking, delay discounting, and long-term planning (Casey et al. 2008; Steinberg 2010). Developmental research consistently shows that adolescents show heightened sensitivity to immediate rewards compared to delayed outcomes, and have a reduced capacity to weigh long-term consequences against immediate gains, a phenomenon known as temporal discounting (Steinberg 2009). These developmental characteristics have direct clinical implications: (1) interventions that rely on future-consequence motivation are less effective with younger adolescents; (2) psychoeducation and cognitive-behavioral approaches need to be developmentally scaffolded to account for limited capacity for abstract future-oriented thinking; and (3) the interpretation of behaviors such as recidivism, treatment non-engagement, and emotional dysregulation must consider that these may reflect normative developmental limitations rather than volitional non-compliance.

Data on mental health needs of justice-involved youth in low- and middle-income countries (LMICs) are inadequate. LMICs struggle with a lack of resources, which also affects their ability to hire mental health professionals and obtain standardized intervention materials and modules (Ramaswamy et al. 2022). Almost 90% of the original research articles and 100% of the reviews in a global scoping review on mental health of justice-involved youth were from high-income countries, the majority of which were from the United States (Borschmann et al. 2020). In Jordan, a study of 158 justice-involved youth incarcerated across five rehabilitation centers found that more than 70% had mental health problems that often went undetected and untreated, with depression notably pervasive and a complex, intertwined relationship observed between depression, anxiety, and delinquency (Dardas et al. 2025). In sub-Saharan Africa, community violence has been identified as a particularly significant contextual driver of internalizing symptoms among adolescents. A systematic review of 42 studies found that higher exposure to community violence was consistently and positively associated with internalizing mental health symptoms in adolescents, with being a victim of violence being more harmful to

mental health than witnessing it, and female sex and absence of family support identified as risk factors for greater internalizing burden (Miliauskas et al. 2022). In South Africa specifically, pathways from community violence exposure to internalizing problems were found to operate through disrupted parent and peer relationships, against a backdrop of historical discrimination and chronic structural disadvantage (Donenberg et al. 2020). A cross-sectional study of juvenile detainees in South Korea found that 90.8% had at least one psychiatric diagnosis, with major depressive disorder present in approximately a quarter of the sample and internalizing disorders including anxiety, PTSD, and generalized anxiety disorder: each identified in around 9%, with female detainees showing significantly higher rates of depression, anxiety, somatic complaints, and suicidal ideation than their male counterparts (Choi and Kim 2023; Kim et al. 2017). A 2025 study of 500 male juvenile offenders in southwestern China found that childhood abuse predicted depressive symptoms, which in turn mediated psychotic experiences, with insomnia as an additional sequential mediator, together accounting for 28.4% of the variance in psychotic experiences (Wang et al. 2025; Z. Zhou et al. 2012).

Access to high-quality mental healthcare services is inadequate, despite the high prevalence of child and adolescent mental health issues in low- and middle-income countries (LMICs), which might be linked to poverty and childhood adversity. While improving access to mental health services remains a priority, evidence consistently shows that structural barriers alone do not explain the treatment gap. Epidemiological research on perceived barriers to mental health care use demonstrates that attitudinal barriers particularly the lack of perceived need for treatment are the most common self-reported reasons for not accessing care, and these same attitude based barriers may persist even when alternative modalities such as digital mental health interventions are made available (Starvaggi and Lorenzo-Luaces 2025). Complementing this, a recent systematic review of the treatment gap in LMICs found that patient-related attitude based barriers including the perception of being labeled as “weak” or “crazy” played a significant role in limiting help-seeking behavior, even in settings where community-level surveys confirmed a high prevalence of diagnosable disorders (Rajan et al. 2025). We critically need more thorough, independent studies on the mental health of justice-involved youth incarcerated in the LMIC context. In order to guide targeted, evidence-based preventive initiatives to address the social and structural determinants of adolescent detention and to promptly deliver health care to this highly marginalized group, more high-quality data, particularly from LMICs, are desperately needed (Juengsiragulwit 2015). Figure 1 illustrates the socio-ecological framework based on Bronfenbrenner’s Ecological Systems Theory (Flynn and Mathias 2023) adapted for juvenile justice context, showing how environmental factors at four nested levels: macro, community, family, and individual converge through two shared mechanisms (chronic stress and ineffectual coping) to produce internalizing disorders. The internalizing disorders box captures the full range discussed in the manuscript such as depression, anxiety, PTSD, dissociation, low self-esteem, NSSI, and suicidal ideation. These then link to the downstream outcomes of antisocial behavior, juvenile offending, and recidivism risk, with a dashed feedback loop indicating the bidirectional and compounding nature of these relationships over time.

4 | Neurodevelopmental Disorders

There is mounting evidence that neurodevelopmental and cognitive disorders are associated with severe criminal activity in recent years (Ishikawa and Raine 2003). The influences of functional difficulties have been highlighted in reflections on the relationships between neurodevelopmental impairment and adolescent antisocial behavior. These influences include both direct influences on susceptibility to certain behaviors in particular criminogenic contexts and indirect influences through increased exposure to social and environmental risk factors for offending (Catroppa and Anderson 2009). According to a meta-analysis encompassing 20 studies (Pratt et al. 2002), ADHD is a significant predictor of criminality. Hyperactivity and impulsivity, two specific symptoms of ADHD, are also closely linked to criminal behavior (Jolliffe and Farrington 2009). It is suggested that this relationship is indirect and mediated by the emergence of conduct disorders, drug abuse, and peer criminality (Eklund and Klinteberg 2003). There is also conflicting evidence that suggests incarcerated youth have a higher incidence of autism spectrum disorder than the general population. Studies often rely on convenience samples or institution-based sampling frames, such as detention centers or clinical referrals, which may overrepresent youth with more severe or identified problems and miss those who are undiagnosed or not captured in these settings (Ali 2018).

The Northwestern Juvenile Project (Lansing et al. 2014), a stratified random sample of 1829 newly detained juveniles (10–18 years old) from Cook County, Illinois, was the subject of a study that evaluated cognitive functioning. The findings showed that justice-involved youths have significantly lower cognitive functioning than the general population. All of the subjects had below-average scores on almost all measures of cognitive functioning, including general intellectual capacity, receptive language abilities, and basic academic success. When compared to previous studies on justice-involved youths and the general population, the level of cognitive impairment in this cohort is noteworthy. The sample’s estimated full-scale IQ was roughly 20 points (1.3 SD) lower than the population’s mean full-scale IQ. Compared to girls, males performed noticeably lower on mathematics, reading, and receptive vocabulary tests. Males were more likely than girls to have more neurodevelopmental abnormalities, disruptive behavior disorders, and learning difficulties, such as delayed verbal milestones and reading failure (Lansing et al. 2014).

5 | Internalizing Disorders

Among justice-involved youth, internalizing disorders including anxiety disorders, PTSD, and depressive disorders are highly prevalent and produce significant functional impairment (Costello et al. 2005; Fan et al. 2025; GBD 2019 Mental Disorders Collaborators 2022). These lead to an increased risk for suicide, and cause psychological, cognitive, social, and vocational impairment (Asselmann et al. 2018; Lijster et al. 2018; Kertz et al. 2019). In a meta-analytic review (Assink et al. 2015), out of the 14 risk domains examined, criminal history and aggressiveness showed the strongest effects on lifetime persistent offending relative to adolescence-limited offending, followed by alcohol and drug abuse, sexual behavior, relationships, emotional and

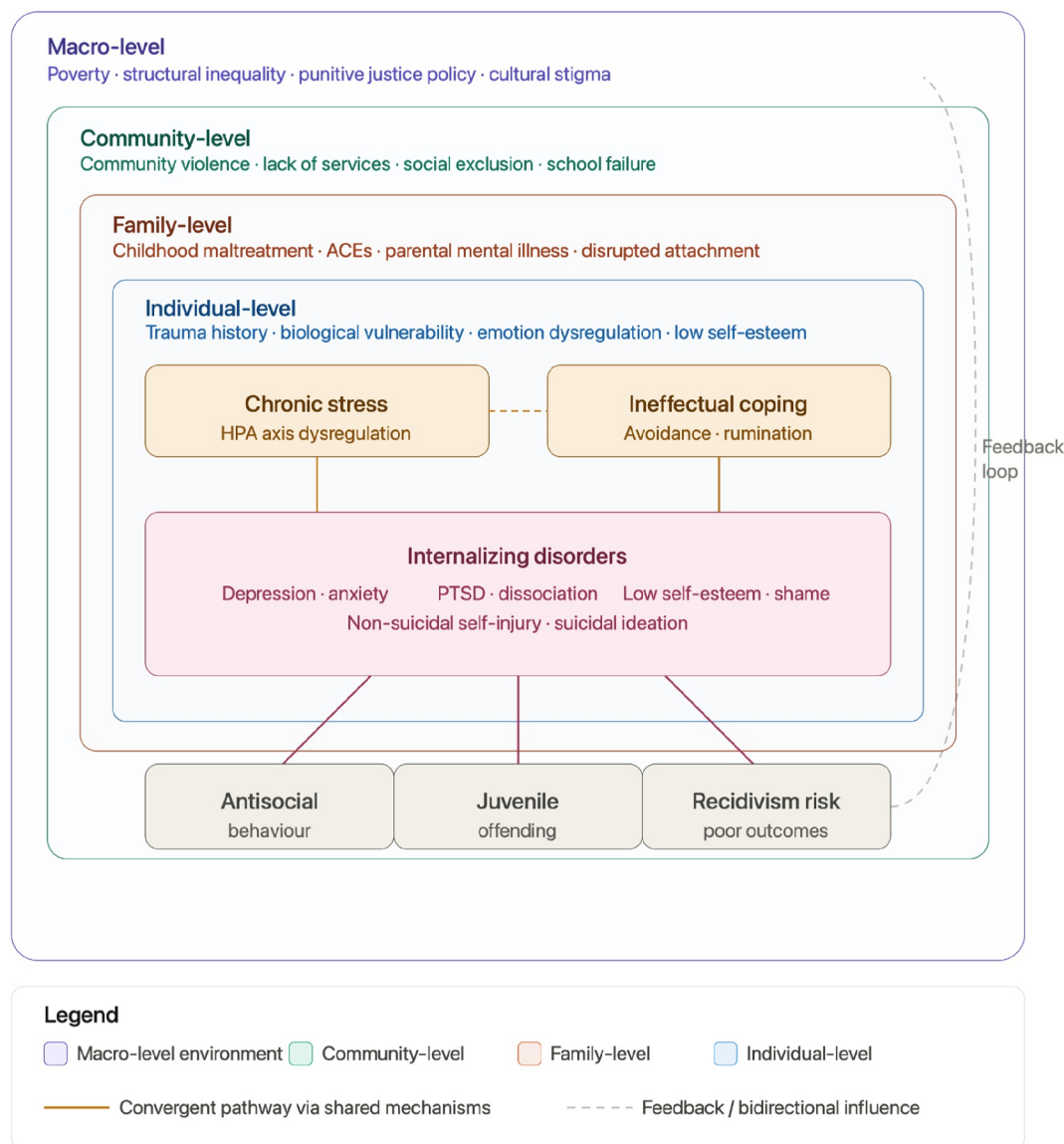


FIGURE 1 | Socio-ecological environmental pathways linking youth internalizing disorders with associated adverse outcomes.

behavioral problems, and school/employment. These are encouraging findings because the pattern of conduct associated with these risk domains is dynamic in nature and can be targeted by intervention strategies. It is also noteworthy to observe that, in contrast to other risk domains, the family domain had a very minor impact on children and adolescents. There are significant environmental factors; notably childhood trauma was linked to internalizing symptoms like high negative affectivity and withdrawal. These findings further warrant a review of the internalizing domain's shared psychosocial risks with justice-involved youth (Assink et al. 2015).

5.1 | Antisocial Behavior

An empirical study on the relationship between internalizing symptoms and antisocial behavior found an association between increased internalizing symptoms and serious chronic violent patterns of offending among adolescents (Sheidow et al. 2008). A sample of juvenile offenders ($n = 192$) in Manchester, UK

(Dolan et al. 1999) found that one in four juveniles engaged in “high risk” behaviors, such as purposefully driving a car into an accident or jumping from heights, while nearly one in 10 claimed intentionally harming themselves. A study used a number of well-validated instruments evaluating psychiatric and mental health symptomatology in the National Health Service (NHS) region, including the K-SADS-E (Ambrosini 2000) to undertake extensive assessments on 57 children in criminal settings and 59 in welfare establishments. They found that depression was present among one in eight children, and 11 out of 15 juveniles with serious mental illness and all 13 juveniles who had experienced sexual abuse were not receiving appropriate treatment (Nicol et al. 2000).

The K-SADS-E was also used in a study (Dimond et al. 2001) to conduct interviews among 19 justice-involved youth. They noted that substance abuse, mood disorders, and conduct disorders were all highly prevalent. An extensive study (Lader et al. 2003) on behalf of the Office of National Statistics,

gathering data on 590 juvenile male and female offenders. They then used well-validated psychometric assessments for personality, psychiatric, affective, and neurotic disorders during clinical interviews, with one in five of the sample experiencing these disorders. It has been reported that over 90% of male juvenile offenders serving sentences fulfill the criteria for a personality disorder. Specifically, eight out of 10 satisfy criteria for antisocial personality disorder, and nearly one out of four meet the criteria for paranoid personality disorder.

5.2 | Childhood Maltreatment

Childhood trauma has long been associated with juvenile offending, and is a known risk factor for internalizing disorders such as depressive and anxiety disorder, as well as PTSD. Childhood trauma is important to recognize because extensive research shows that abuse, neglect, and exposure to violence significantly increase the risk of juvenile offending, supporting the idea that early trauma can contribute to a “cycle of violence” across development.

Children who have a history of abuse or neglect are more likely to be arrested for violent crimes (Widom et al. 2014). Studies also show that children who have witnessed abuse or neglect are more likely to commit violent crimes compared to children without a trauma history (Stouthamer-Loeber et al. 2001; Widom et al. 2014). Child abuse and neglect (CAN) raises a child's risk of violence as well as adult criminality and offending, with both sexes at risk for criminal behavior. In a systematic review, physical abuse and punishment were identified as explanatory risk factors for offending (Widom and Wilson 2015). After carefully examining prospective longitudinal studies, an analysis of the available data came to the conclusion that parental physical abuse is associated with violent offending in the abused children (Braga et al. 2017).

In order to investigate the relationship between the experiences of childhood maltreatment and subsequent criminal behavior, an exploratory analysis (Chen et al. 2024) of 1227 female juveniles in China who had been placed under house arrest for a variety of offenses was conducted. The results indicated a strong correlation between the criminal behavior of juvenile females and their experiences of childhood maltreatment, particularly emotional abuse, physical abuse, and emotional neglect. The degree of emotional abuse, physical abuse, and emotional neglect varied significantly throughout the different categories of criminal activity, suggesting that the intensity of maltreatment may affect young women's propensity to commit different kinds of crimes. To support the “cycle of violence” theory, which holds that children often imitate their parents' actions; 11.4% of children who had not been exposed to child maltreatment (CM) reported being involved in violent offending, compared to roughly 20% of children who encountered mild CM and nearly three times as high (30.4%) among children who reported severe CM. Similarly, 13% of students who had not experienced intimate partner violence (IPV) reported engaging in violent offending behavior, compared to 20% of students who had experienced mild IPV and 24% of students who had experienced severe IPV (Steketee et al. 2021).

5.3 | Trauma

The relationship between trauma exposure and justice system involvement among youth is significant. Recent study found that increasing exposure to trauma was predictive of a wide range of mental health conditions including irritability, depression, anxiety, suicidal ideation and substance use, and this relationship strengthened with an increasing number of admissions to juvenile detention (Kerig et al. 2025). The implications were thought to be that trauma exposure decreases the likelihood of an offending juvenile returning to a normal psychosocial trajectory, thus mediating recidivism. Though not explicitly studied in this research, we wonder whether the empirical worsening in mental health with an increasing number of juvenile incarcerations may have been partially associated with traumatic exposure during incarceration. This raises complex questions about iatrogenic harm in the juvenile justice system. Though data is scarce among juveniles, studies show that traumatic exposure is prevalent during incarceration, and affects people living with mental illness at a higher rate (Armas et al. 2026).

Adolescents involved in the justice system are known to encounter potentially traumatic events. For instance, surveys of 16–20-year-olds ($n = 898$) in detention in the USA (Costello et al. 2002) and 10–18-year-olds ($n = 590$) detained in England and Wales (Abram et al. 2004; Lader et al. 2003) both revealed that more than 90% had experienced at least one potentially traumatic event. The study did not differentiate between trauma experienced during detention and outside. Additionally, in a Nigerian study (Atilola et al. 2014), 204 youth involved in the court system had an 88.7% rate of exposure to trauma with a mean age of 15.9 years, compared to 48.5% in a comparison group of 204 secondary school students. Studies indicate that justice-involved youth have higher rates of posttraumatic stress disorder (PTSD) (Abram et al. 2004; Becker and Kerig 2011). Within the US criminal justice system, the lifetime prevalence of PTSD in incarcerated youth aged 10 to 18 ranges from 10% to 37%. Other national settings reflect similar rates, including 20% in Australia (Becker and Kerig 2011), 25% in Russia (Moore et al. 2013), and 36% in Japan (partial criteria) (Yoshinaga et al. 2004).

5.4 | Non Suicidal Self Injury (NSSI)

Nonsuicidal self injury (NSSI) is defined as the intentional, self-inflicted destruction of bodily tissue that results in immediate harm, without suicidal intent, and for reasons that are not culturally acceptable (Cipriano et al. 2017). NSSI is thought to be a maladaptive response to an overwhelming internal stressor (depression, anxiety, rejection, self-directed hatred) and is highly prevalent among justice-involved youth, with one study suggesting a prevalence of 58.2% among Indian juvenile offenders (Tilak et al. 2025). Its presence should warrant careful psychiatric and safety assessment, especially due to its association with severe affective disorders like MDD and Borderline personality disorder as well as its status as a known risk factor for concurrent or future suicidal behavior and completed suicide (Herzog et al. 2022). A structured face-to-face interview conducted among 181 Sri Lankan juvenile offenders (Hettiarachchi

et al. 2018) reported self-harm, whether NSSI or with suicidal intent, among 43% of participants. The occurrence of self-harm was connected with female sex, prior sexual abuse victimization, prior exposure to self-harm by friends, and a lifelong history of self-harm urges.

NSSI, when co-occurring with harm towards others in adolescents, is more predictive of subsequent offending, compared to NSSI on its own. Compared to other groups, adolescents who additionally self-harm have a history of higher levels of physical aggression, strict parents, and poorer school bonding. As early adults, they are more likely to report psychopathy, victimization experiences, violent thoughts, and anxiety/depressive symptoms (Steinhoff et al. 2023).

The Kiddie-Schedule of Affective illnesses and Schizophrenia (K-SADS-PL) was used to measure NSSI, suicidality, and mental illnesses in a study that included 397 adolescents aged 12–19 years who were placed in youth welfare and juvenile justice group homes. There were lifetime prevalence rates of 18.4% and 21.9% for repeated and occasional NSSI respectively, and 85.6% of the sample was found with mental illness. For both sexes, there was a substantial correlation between periodic and recurrent NSSI and conduct, depression, and drug use disorders (Lüdtke et al. 2018).

5.5 | Suicide

It has been found that justice-involved youth are at an increased risk for suicide (Heirigs et al. 2019). According to a study, almost one in five male detained young offenders (ages 16–20 years) had made suicide attempt the year prior, while a third of female young offenders stated that they had attempted suicide at least once in their lives (Lader et al. 2003). Exposure to suicide is also high in this population. According to a 2003 interview-focused study (Hales et al. 2015), almost a third of 151 incarcerated young offenders aged 16–21 said they knew someone who had killed themselves. In this group, suicidal behavior was linked to the frequency of interaction with people who had attempted suicide (Hales et al. 2015).

A Diagnostic Interview Schedule for Children (Abram et al. 2008) was used to measure death thoughts, suicidal ideation, suicide plans, lifetime suicide attempts, number of attempts, age at first attempt, attempts within the last 6 months, method of suicide attempts, and psychiatric disorders. In the 6 months prior to being placed under detention, over one-third of juvenile offenders and almost half of female juvenile offenders reported feeling hopeless or considering suicide. Around one in 10 juvenile detainees had considered suicide in the past 6 months, and one in 10 had ever attempted suicide.

5.6 | Depression and Anxiety

A meta-analysis (Fazel et al. 2008) of 25 studies, comprising 16,750 justice-involved youth (age range 10–19 years), from the USA (15 studies), the UK (four studies), Australia, Russia, the Netherlands, Denmark, Canada, and Spain (one study each), revealed that approximately 29% of females and 11% of males had major depressive disorder. A comparable 10% frequency was noted among 370 Russian juvenile detainees (V. V. Ruchkin

et al. 2002). By contrast, the global pooled prevalence of MDD in the general adolescent population was found to be 3.7% (95% CI, 2.7%–5.1%) (Lu et al. 2024). A longitudinal sample of 3604 adolescents from ages 12 to 17 was analyzed (Kofler et al. 2011) to study whether depressive symptoms at the baseline age of 12 predicted longitudinal offending. The results showed a significant relationship between depressive symptoms and offending behavior, both at the outset and in their patterns of age-related change. Additionally, the study showed that depressive symptoms predicted concurrent offending behavior and vice versa, suggesting a significant bi-directional relationship between depressive symptoms and offending throughout adolescence.

Anxiety disorders affect about 4–4% of people between the ages of 11 and 16 years old. In contrast, rates of diagnosis for young people between the ages of 12 and 18 in criminal justice institutions in the USA (Teplin et al. 2002; Wasserman et al. 2010), the UK (Kroll et al. 2002), and the Netherlands (Vreugdenhil et al. 2004) range from 9% to 21%. Additionally, a study had proposed that anxiety symptoms arise from both the incarceration process itself and the out-of-home placements that frequently precede incarceration in order to explain the high prevalence of anxiety disorders among juvenile offenders (Ulzen and Hamilton 1998). Using latent growth curve modeling in a sample of 1216 male adolescents followed over five years after first arrest, a study demonstrated that anxiety, depression, and re-offending trajectories moved in parallel where decreases in internalizing symptoms were associated with reductions in offending, and vice versa (Baker et al. 2023). Consistent with this, a meta-analysis of 23 studies involving over 15,000 adolescents identified anxiety and depressive disorders among the strongest predictors of juvenile recidivism (Aalsma et al. 2015). Drawing on 29 studies and 19,420 young people entering custody, it was found that a pooled prevalence of anxiety disorders of 18.7% (95% CI 13.0%–26.0%) at the point of custodial entry, making anxiety the second most prevalent disorder after conduct disorder, and substantially exceeding rates seen in the general adolescent population. Importantly, anxiety rarely presents in isolation in this population (Murie et al. 2026). In a study of 276 detained youth across two pre-adjudication facilities, it was found that more than 35% of participants reported clinically significant symptoms of depression and more than 26% reported elevated symptoms of anxiety, with elevated internalizing symptoms present across all charge types rather than being confined to specific offenses. The co-occurrence of anxiety and depression in this population carries specific implications for offending trajectories (Liu et al. 2025). Using nationally representative longitudinal data, a study (Silver et al. 2024) demonstrated bidirectional, within-individual associations between symptoms of depression and anxiety and contact with the criminal justice system with internalizing symptoms both preceding and following arrest, consistent with a reciprocal rather than unidirectional causal model.

5.7 | Other Conditions

This section includes internalizing pathology with low prevalence rates (Karnik et al. 2009; S. Young et al. 2015) among the justice-involved youth population, including OCD, panic disorder, specific phobias, social anxiety disorder and eating disorders. On literature review, there were no data comparing the

prevalence of the above disorders with the general adolescent population, or discourse on reasons for their relative paucity. Overall, their clinical relevance for juvenile justice systems appears to be low. Regarding OCD, though data are heterogeneous, low prevalence among juvenile offenders may be attributed to high neuroticism and low risk-taking, which are thought to be protective against offending behavior (Zhang and Takahashi 2024).

We found that somatic complaints are prevalent among justice-involved youth, with notable links to traumatic exposure (Kerig et al. 2025). In the literature, somatoform disorders are sometimes imagined as internalizing pathology due to being an inward-directed response to an emotional stressor, but are formally characterized in their own category under the Hierarchical Taxonomy of Psychopathology (HiTOP) model (Sanchez-Garcia et al. 2026). Another ambiguous category is the bipolar spectrum mood disorders, which though highly relevant to adult offenders, is not common among justice-involved youth, largely owing to its age of onset being more often in adulthood. This category of disorders also sits uneasily at the cusp of internalizing and thought disorders, and the implications for criminal behavior are thought to be more associated with the manic and psychotic phases of illness than the depressive phase.

Dissociative Identity Disorder (DID), is a rare psychiatric disorder wherein an individual has two or more distinct identities or alter egos that are different from their true self (Sar 2016). This disorder is not noted among justice-involved populations, whether juvenile or adult, and data are sparse. However, it is linked with early trauma exposure and includes emotional disturbances like a lack of safety, direction, and the inability to recognize or react to warning signs. If untreated, DID can lead to recurrent violent incidents in adolescence and adulthood (Abd Kadir and Mohd Salleh 2021). Statistics compiled by physicians reveal that almost half of patients with DID exhibit aggressive behavior (Webermann and Brand 2017). Based on data in adult offenders, DID is commonly fabricated and notoriously difficult to treat, warranting careful assessment and intensive, long-term psychodynamic psychotherapy. Its low prevalence and complex management puts it beyond the scope of systemic therapeutic intervention for most juvenile justice systems (Kabene et al. 2022).

The components of internalizing domains contributing to juvenile offense is provided in Figure 2.

6 | Cross-Relationships Between Various Factors

There is a notable overlap between internalizing and externalizing disorders, as well as between various disorders within each category. The growing body of research on the characteristics of ODD and CD symptoms and how they relate to internalizing disorders is also significant. ODD during early life is predictive of persistent mental health challenges, and ODD and CD may be consistently separated from normal behavioral problems as early as preschool (Keenan and Wakschlag 2002). According to a study (Kerr et al. 1997), behavioral inhibition appeared to protect male children from both disruptive and non-disruptive offending. Those who were disruptive and lacked inhibition had a higher probability of becoming justice-involved youth

than those who were inhibited. However, social withdrawal increased the risk of offending, with the withdrawn subset of disruptive offenders having a higher risk of future justice involvement. A study on the multi-trajectories of externalizing and internalizing behaviors from age 6–12 years showed diverging results in the context of internalizing symptoms, mainly due to the lack of specific analysis of sub-features and the use of broad measures (Commisso et al. 2024). This overlap increases the complexity of treatment, and underscores the importance of addressing both types of disorders in rehabilitation programs.

Justice-involved youth were voluntarily recruited for a Russian study (V. Ruchkin et al. 2017) over a 6-month period from a correctional facility housing about 300 male juvenile offenders. The study's findings showed that suicidal thoughts and attempts were frequent among justice-involved youth in Russia (Casiano et al. 2013) where 40.4% of the participants said they had previously attempted suicide or recently experienced suicidal thoughts. There were also notable differences between juvenile offenders who had a history of suicidal thoughts and attempts and those who did not in terms of major depression, post-traumatic stress disorder, conduct disorder, ADHD, anxiety disorders, and alcohol dependence. The study findings strengthen the case for implementing suicide risk and mental health screenings in juvenile justice settings. This need is particularly felt in the Russian context, where the paradigm shift from punitive to rehabilitative juvenile correction has been slow, and marred by administrative barriers and outdated practices (Dutkiewicz 2009).

Some data shows that internalizing disorders do not increase juvenile offending in the presence of externalizing disorders. A study recruited 729 participants aged 5–17 years in Hawaii, where the analysis showed that while children with ADHD alone were noticeably more aggressive than those with comorbid ADHD and anxiety, children with anxiety alone were equivalent to those with ADHD plus anxiety (Falk et al. 2017). Regarding depression, the data are variable. Few structured clinical interviews were conducted (Kang et al. 2015) with 489 juvenile offenders to investigate aggression, prior suicide attempts, and substance use disorders in juvenile offenders with subclinical depression versus juvenile offenders with significant depression or no mood problems. Analyses showed that while juvenile offenders with major depression did not differ significantly on aggression and substance abuse, those with subclinical depression reported significantly higher levels of aggression, substance abuse, and a history of attempted suicide when compared to juvenile offenders without a mood disorder.

In epidemiological samples of community populations, the relationship between antisocial behavior and depression in adolescence is well established. A longitudinal study found that these correlations are greater in young women when compared to young men (Moffitt et al. 2001). According to a meta-analysis encompassing 20 studies (Pratt et al. 2002), ADHD is a significant predictor of criminality. Hyperactivity and impulsivity, two specific symptoms of ADHD, are also closely linked to criminal behavior (Jolliffe and Farrington 2009). It is suggested that this relationship is indirect and mediated by the emergence of conduct disorders, drug abuse, and peer criminality (Eklund

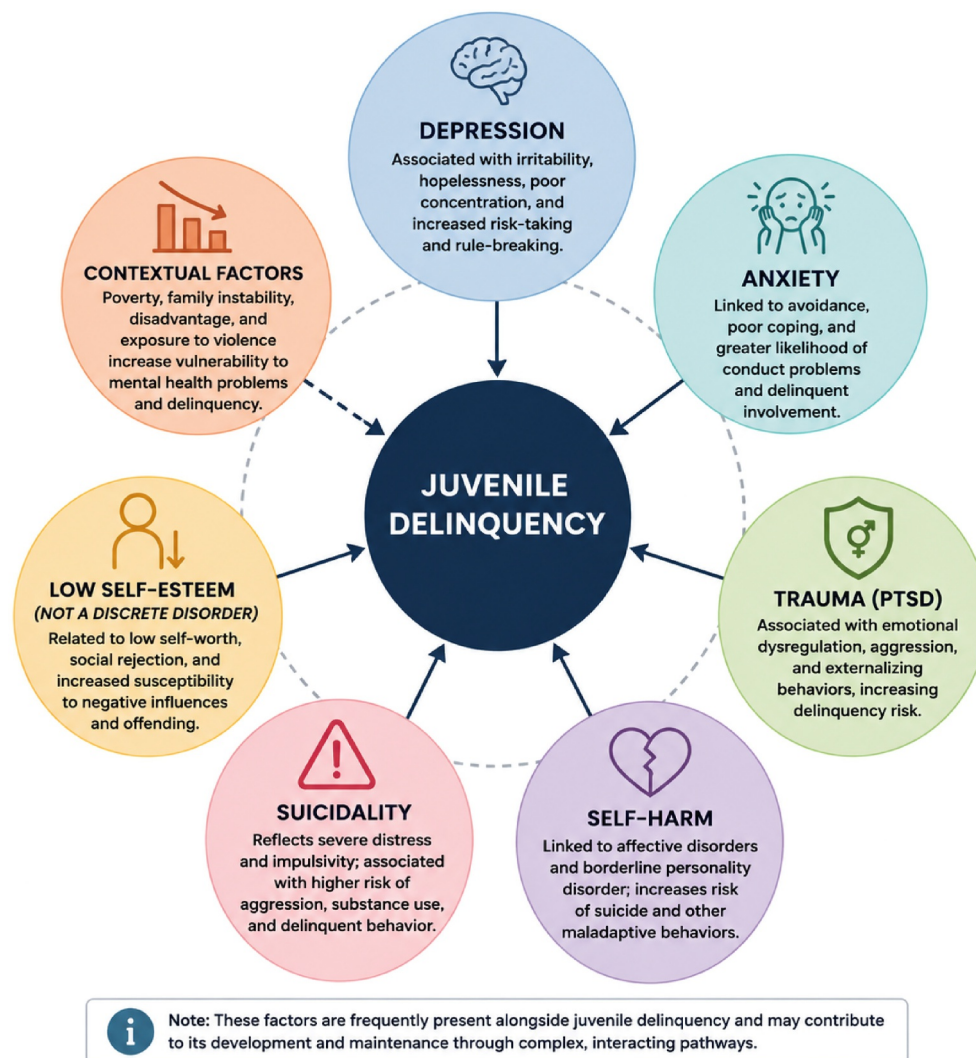


FIGURE 2 | Key internalizing domains in juvenile offending.

and Klinteberg 2003). There is also conflicting evidence that suggests incarcerated youth have a higher incidence of autism spectrum disorder than the general population. This is because studies have a tendency to employ certain samples and sampling frames, which makes it challenging to determine prevalence (Ali 2018).

The Woodlawn sample, an epidemiologically defined community cohort of African American males and females from Woodlawn, Chicago, was studied (Doherty et al. 2008) which reported that for both groups (serious and non-serious offenders), the cumulative incidence rate of marijuana use rises sharply between the ages of 12 and 20 before leveling off in the early 20s. For serious offenders, the cumulative incidence rises to 74% by the age of 26, and it stays there until mid-adulthood. For non-serious offenders, a similar trend is seen: 58% start using marijuana by the age of 20, and they continue to do so until they are 42. Although at lower incidence rates, the results of a survival analysis for the unmatched sample on cocaine initiation with serious justice-involved youth are comparable to those of marijuana usage. When it comes to cocaine, serious offenders have a cumulative incidence of 53% by the age of 42, compared to 26% for non-serious offenders. Overall, serious

adolescent offending increases the probability of initiation of drug use, including marijuana and cocaine.

Using a two-stage stratified cluster sample of children, a secondary data analysis was conducted of NSCAW II (Brown and Shillington 2017), a national longitudinal study of 5873 children and youth ages birth to 18 years who had investigations of child maltreatment by child welfare agencies in the United States. The six-item CRAFFT (Car, Relax, Alone, Friends, Forget, Trouble) youth self-report questionnaire from the Youth Risk Behavior Survey was used to measure substance use. The entire model's statistics for substance use were statistically significant. Substance use variation was significantly explained by the interplay between protective adult relationships and adverse childhood experiences (ACEs), such that ACEs were more strongly associated with substance use in youth with lower levels of protective adult relationships. However, this association was not statistically significant in youth with higher levels of protective adult relationships.

Additionally, the avoidance-focused emotion regulation processes that have been most extensively researched in relation to self-harm include dissociative tendencies and experiential

avoidance (EA). However, little is known about the relationships between NSSI and emotion dysregulation in young people who are incarcerated. A study conducted among male Hungarian justice-involved youths noted that maladaptive defensive or coping strategies, like clinically increased dissociation or EA, may increase the likelihood of NSSI or serve as its basis (Reinhardt et al. 2022).

7 | Neuropsychiatric Interventions

Interventions for juvenile offenders should target mental health issues, but they are unlikely to have a positive impact on criminogenic outcomes if they only address clinical issues (Schubert et al. 2011). Effective therapies that meet this group's criminogenic and therapeutic needs are therefore clearly needed. For juvenile offenders, cognitive-behavioral methods work very well. The National Mental Health Association (John and Foundation 2004) claims that because it is structured and focuses on the things that lead to disruptive or aggressive conduct, this method works very well for young people who are involved in the judicial system.

7.1 | Cognitive-Behavioral Interventions (TFAC, CBT, SNAP)

A cognitive behavioral intervention known as Thinking For a Change (TFAC) (Bush et al. 2001), where, by combining several cognitive techniques, the program seeks to teach pro-social cognitive skills and reframe the thinking of young offenders. The curriculum consists of 22 problem-solving courses that are given once a week in small groups for around two hours. Programs that include these treatment choices are not common in most jurisdictions, despite evidence that intense cognitive behavioral skills training is extremely beneficial (Shelton 2005).

Children with CD can be prevented from engaging in criminal activity in the future by receiving early identification and treatment. Research indicates that children with CD under the age of 12 may benefit from cognitive-behavioral therapies (CBT). One of the CBT therapies, Stop Now, And Plan (SNAP), is offered in community settings to children under the age of 12 who exhibit violent and antisocial behavior. A meta-analysis (Osman 2020) reveals that after 9 months of involvement in the program, the children's offending behavior significantly decreased. According to the RCTs, the study's findings with teacher reports demonstrated that SNAP was highly successful in lowering criminal convictions for young people who reached the age of criminal responsibility after 15–18 months of program participation. Observational studies showed that this trend persisted for up to 11 years of follow-up. Additionally, immediately following the 3-month treatment, the children's behavioral issues significantly decreased, and their social competency levels increased. This pattern persisted for the full 6-month follow-up period.

7.2 | Mindfulness-Based Interventions (MBCT, MBSR)

Mindfulness-based therapies have also been studied in justice-involved youth. Examples of these include mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress

reduction (MBSR). MBSR is an 8-week mindfulness technique that involves group mindfulness sessions whereas the main goal of MBCT is to help individuals recognize negative thoughts and feelings intellectually and then view them in an open, nonjudgmental manner. According to a review conducted in New Zealand (Murray et al. 2018), mindfulness-based therapies led to better anger control, self-regulation, reduced stress, and good youth acceptance of the interventions. A scoping review (Simpson et al. 2018) found that participants reported feeling more at ease, more capable of handling stress, more self-aware, more capable of self-regulation, and more hopeful about the future. This increase in internal well-being led to outward shifts, like better social connections, appreciating the teacher's generosity, and perceiving a nurturing atmosphere, where they felt appreciated and respected. Additionally, participants expressed a sense of empowerment after overcoming the discomfort of maintaining mindfulness. They felt more in control, had better relationships with peers, family, and staff, valued being a member of the group, and were better equipped to handle challenging emotions and impulses. They particularly valued being handled with consideration, decency, and compassion. Interestingly, according to another meta-analysis (X. Zhou et al. 2020), MBSR considerably outperformed other control conditions in lowering incarcerated youth's anxiety symptoms even in comparison with standard of care.

7.3 | Evidence and Family-Based and Multisystemic Interventions (ICT, FFT, MST, MTFC, MET, FIT)

For incarcerated youth; multisystemic therapy, functional family therapy, and multidimensional treatment foster care are potential or successful interventions (Wittenberg 2006). The Integrated Co-occurring Treatment (ICT) model (Clemishaw et al. 2005) for youth is a component model of care that is tailored to the unique requirements of incarcerated youth with co-occurring mental health and substance abuse disorders. Nowadays, it is used by several evidence-based therapies, such as Functional Family Therapy, Multisystemic Therapy, and Multidimensional Family Therapy. These approaches include elements of juvenile offender treatment that have been found to be advantageous and preventative when offered by the legal system (Underwood et al. 2006, 2014). Those aged between 11 and 18 years, who are at risk for, or already exhibit offending, aggression, substance use, CD, ODD, or other disruptive behavior disorders, are frequently treated with functional family therapy (FFT). According to one study, kids who received FFT had a 25% re-arrest rate, while those who were seen in juvenile court, had no treatment, or received usual care had a 45–70% re-arrest rate (Shelton 2005). According to a 5-year follow-up study, compared to 60% of adolescents seen in juvenile court, less than 10% of youth receiving FFT had additional arrests (John and Foundation 2004). Although FFT has been demonstrated to be a successful model for lowering recidivism, studies also suggest a need for behavioral health clinicians to receive FFT model training.

Evidence-based interventions including Multisystemic Therapy, Motivational Enhancement Therapy (MET), Relapse Prevention, and Dialectical Behavior Therapy (DBT), are all part of the Family Integrative Transition (FIT) program. This intensive

therapy program starts 2 months before the juvenile's scheduled release date and lasts for four to 6 months as the juvenile gets used to reintegrating into society (Trupin et al. 2011). According to evaluation studies (Aos et al. 2004), the recidivism rate for FIT participants was 27%, while the rate for non-participants was 40%.

Multi Systemic Therapy (MST) is a family-based, multimodal, intensive strategy that aligns treatment with the known causes and contributing factors of substance abuse and offending. Through MST, re-arrest rates have been shown to drop by as much as 70%, out-of-home placement rates decreased by as much as 64%, family functioning improved, and mental health issues among juvenile offenders decreased (John and Foundation 2004). At 18 and 6 months after treatment, the use of MST resulted in notable decreases in rearrests and enhancements in four domains of functioning as assessed by the Child and Adolescent Functional Assessment scale (Timmons-Mitchell et al. 2006). This also further supports the idea that community-based treatment may be the most appropriate for justice-involved youths with mental health issues by using a real-world mental health environment with youth involved in juvenile court.

For adolescents with severe and persistent emotional and behavioral issues, Multidimensional Treatment Foster Care (MTFC) offers an alternative to group, residential, secure-care, or inpatient treatment. For roughly six to 9 months, adolescents are placed with trained, nearby, and closely watched families. Outcome studies on MTFC programs have shown that kids who received services had considerably fewer arrests and spent 60% fewer days in detention than those who did not (John and Foundation 2004). The MTFC further slowed down girls' depressed symptoms and was more beneficial for girls who had higher starting depressive symptoms (Harold et al. 2013). A randomized evaluation (Leve and Chamberlain 2007) noted that

MTFC also showed effectiveness for non-targeted goals like pregnancy, attendance at school, and assignment completion in girls.

7.4 | Community and Wraparound Approaches

The system-of-care structure is connected to the wraparound approach (Olson et al. 2021) which is another potential intervention for juvenile offending. Systems-of-care are comprehensive programs that use a coordinated network of mental health and other support services to meet the changing requirements of children and adolescents with severe emotional disorders. They were created by the Child and Adolescent Service System Program (CASSP). Evaluations of the Milwaukee Wraparound program's results showed an 80% decrease in mental hospitalizations and a 60% decrease in residential treatment utilization (Underwood and Washington 2016). According to research, the wraparound process is a promising way to address the mental and emotional needs of young people involved in the legal system, though difficult to implement, due to intensive resource needs and multi-system cooperation (Schlenger et al. 1992; Suter and Bruns 2009).

7.5 | Trauma-Specific Interventions (TF-CBT, CPT)

According to estimates, 20 to 23% of adolescent offenders fulfill the clinical criteria for PTSD, with girls having much higher prevalence rates than boys (40% vs. 17%) (Dierkhising et al. 2013; Moore et al. 2013). The most successful treatment for adults with PTSD is thought to be Trauma-focused CBT (TF-CBT), which has also shown promise in treating juvenile offenders. Cognitive processing therapy (CPT), an adaptation of CBT, has been noted to significantly reduce self-reported symptoms of depression and PTSD when compared to waitlist controls (Young et al. 2017).. (Figure 3)

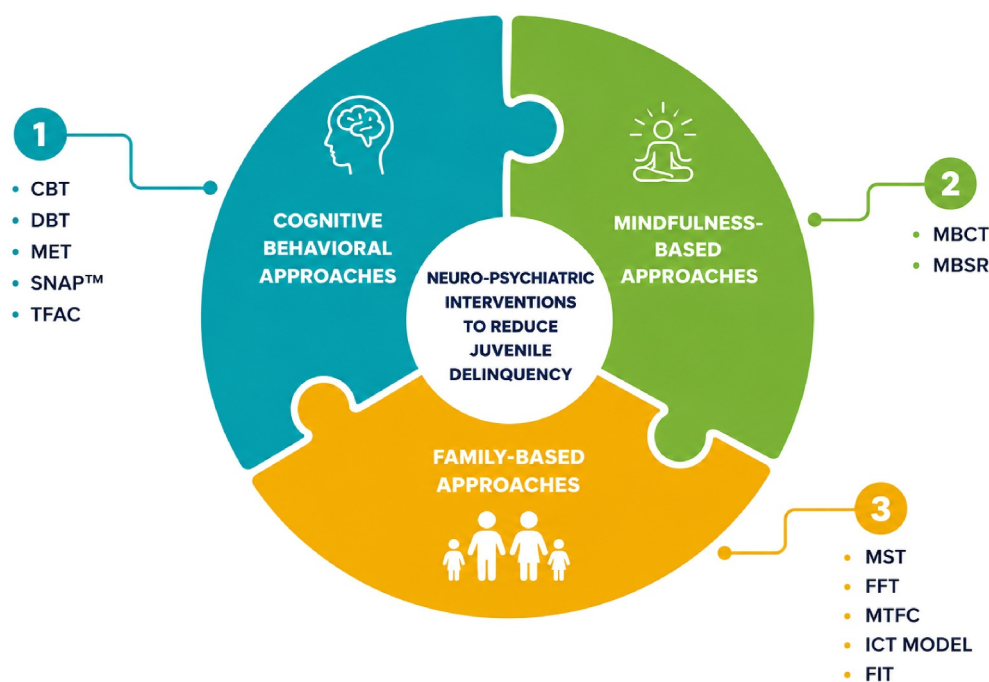


FIGURE 3 | Step puzzle chart showing various approaches for improved outcomes for justice-involved youth.

8 | The LMIC Context

Mental health issues are one of the main reasons why young people around the world lose productivity (Mokdad et al. 2016). There is still a dearth of data on the mental health of adolescents from LMICs, which account for 90% of the world's adolescent population (Kieling et al. 2011). Children and young people living in LMICs are more susceptible to mental illness and the associated high mortality rates because of their social and environmental circumstances, which include higher rates of poverty, violence, and a shortage of medical and psychological care (Lund et al. 2011). According to a meta-analysis (Pozuelo et al. 2022), teenagers in LMICs who suffer from depression bear two burdens: depression and a higher propensity to engage in risky activities. In addition to creating a health burden on society in terms of juvenile offending, this combination may result in physical and psychological health issues that last throughout life.

Interpersonal violence rates differ significantly among LMICs, with Asia having significantly lower rates than Latin America and Africa. Across nations in the same region, violence trends typically follow comparable patterns (Lappi-Seppälä and Lehti 2014). Interestingly, geographic location did not consistently moderate the relationships between variables and violence in an African study (Ribera et al. 2019). Magnitudes still differ from nation to nation even when taking into account correlates that repeat across areas, including male sex (Blumberg et al. 2009; Pickett et al. 2005). Evidence from the Global School-Based Student Health Survey (GSHS) (Nivette et al. 2019), for example, indicates that sex differences in adolescent aggression vary significantly across different LMICs, and countries with higher female adolescent populations tend to have lower gaps between male and female aggression. In India, a review of the National Crime Records Bureau (NCRB) data (Government of India 2022) on juvenile offenses shows a noteworthy pattern between 2013 and 2022. The number of reported crimes fell from 43,506 to 30,555 over this time, representing a decline of 12,951 offenses, or almost 30% over a 10-year period. There are a number of obstacles standing in the way of rehabilitation of juvenile offenders. The stigma of being perceived as an offender or a child who has served time in a juvenile detention facility is the most evident of the various social challenges faced by children in conflict with the law (CICLs). Second, CICLs often utilize dropping out of school as a survival strategy because they are afraid of being stigmatized and going back to the same environments where they were mistreated, which can result in unemployment. Thirdly, family issues are a major factor in recidivism. These issues include parental substance addiction, parental absence, parental incarceration, and parental divorce. If the underlying issues are still there, it could be challenging for CICLs to reunite with their families. Lastly, children placed in observation homes have many opportunities to interact and share knowledge with one another because they are all staying in one location. In this approach, children with a history of less significant offenses can be exposed to more serious ones. Institutes providing sub par rehabilitation services and lack of staff also makes follow-up less effective (Surendran and Gayathri 2023).

To date, reviews of parenting interventions in LMICs have focused on specific topics, such as parenting programs that address early child development (ECD) (Britto et al. 2015), interventions for children with developmental disorders (Hastings et al. 2012), and interventions for enhancing parenting skills and addressing abusive parenting in LMICs (Knerr et al. 2013). Only one recent systematic review (Healy et al. 2018) has examined parenting and family-focused psychosocial therapies more generally for all children and youth in LMICs, despite the encouraging recent growth in the body of research in this area. One of the biggest obstacles to receiving high-quality care in LMICs is the lack of capacity in mental health workforces. Professional care requires the right infrastructure, supervision, and training, but in LMICs, these resources are frequently scarce, as is the availability of qualified professionals (Saraceno et al. 2007; Saxena et al. 2007). New, less expensive methods have been developed and are becoming more and more successful. To increase the coverage of general health and mental health treatments, for instance, task-sharing which is a collaborative model of care in which non-specialists are trained to conduct therapies under the supervision of specialists has proven to be both feasible and beneficial (Patel 2012; Patel et al. 2009).

9 | Clinical Implications and Recommendations

9.1 | For Mental Health Clinicians

- Routine screening for internalizing disorders at intake using validated instruments such as the Child Behavior Checklist, Beck Depression Inventory for Youth, and PTSD Checklist for Children
- Use of evidence-based, developmentally adapted interventions including TF-CBT, DBT-A, and MBSR
- NSSI safety planning and ongoing suicide risk monitoring
- Coordination with correctional staff regarding mental health needs

9.2 | For Correctional and Facility Staff

- Training in trauma-informed care to recognize and respond appropriately to behavioral manifestations of internalizing distress, including irritability, social withdrawal, and somatic complaints
- Reduction of punitive disciplinary practices that may worsen trauma-related symptoms
- Clear protocols for responding to NSSI and suicidal behavior

9.3 | For Policy Makers and Public Health Advocates

- Investment in universal mental health screening at first contact with the justice system
- Training of non-specialist personnel using the task-sharing model, particularly in LMICs
- Expansion of community-based diversion programs providing mental health support outside of detention

- Advocacy for rehabilitation-oriented juvenile justice legislation in settings where punitive models remain dominant

9.4 | For Researchers

- Prioritization of longitudinal studies examining the temporal relationship between internalizing symptoms and reoffending
- Development and validation of culturally adapted screening instruments for use in LMICs
- Conduct of formal systematic reviews and meta-analyses with risk of bias assessment to establish effect sizes for specific interventions across defined subgroups.

10 | Strengths and Limitations

This review brings attention to internalizing disorders that are often overlooked in discussions on justice-involved youths. It synthesizes a wide body of evidence across multiple mental health domains. It highlights the links between inward distress, behavioral problems, and recidivism. It also integrates findings on suicide risk and trauma exposure. The review summarizes a broad range of interventions with demonstrated benefits. It gives special consideration to low and middle income countries where service gaps are substantial. It emphasizes the importance of rehabilitation focused models within the juvenile justice system. It offers a framework for understanding hidden mental health needs in justice-involved youth. It also identifies areas of practice that require urgent strengthening.

However, the review has limitations. It does not fully address social determinants such as poverty, neglect, family conflict, and structural disadvantage. It includes limited discussion on cognitive impairments that influence offending. It depends on studies that vary in quality and methodology. Evidence from many LMICs remains scarce. Data on sex differences are limited in some areas. Longitudinal studies on internalizing symptoms in justice-involved youths are still few. These gaps restrict the depth of available conclusions and highlight the need for further research. Future systematic reviews in this area should include a formal RoB assessment using the Cochrane Risk of Bias tool (for RCTs) or the Newcastle-Ottawa Scale (for cohort and case-control studies), and we note this as a priority for the field.

11 | Conclusion

Internalizing disorders shape the lives of justice-involved adolescents in profound ways that are often unseen. Depression, anxiety, trauma related symptoms and self directed harm influence behavior, heighten vulnerability and increase the risk of repeated contact with the juvenile justice system. These conditions also worsen long term health, social and developmental outcomes. The evidence reviewed in this paper shows that early identification and targeted mental health care can support rehabilitation and reduce recidivism. Effective interventions exist, yet many remain underused, especially in resource constrained settings. A child centered and mental health informed approach is essential for reform. Such an approach can break cycles of distress and offending and promote healthier transitions into adulthood. Continued research on internalizing

symptoms among justice-involved youth is needed to guide policy, strengthen services and prevent avoidable harm.

Author Contributions

C.R. and S.T. Study concept and design. C.R., S.T., J.G. and A.K. Drafting of the manuscript. C.R., S.T., J.G. and A.K. Critical revision of the manuscript for important intellectual content. C.R. and S.T. Administrative, technical, or material support. C.R. and S.T. Study supervision.

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Ethics Statement

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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