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Adolescents Charged With Assault of a Parent: Assessment and Treatment Approaches

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There has been an increase in the number of youths referred to the juvenile justice system for charges related to stressful or chaotic home environments that result in adolescents being charged with domestic violence of a parent. These incidents rarely result in significant injury, yet the justice system's response in some jurisdictions results in detention twice as often as other cases. However, the majority of these youths are not at risk for continued adolescent domestic battery (ADB) or other forms of re-offending, which implies that the preferred response for many would be treatment designed to meet the needs of the youth and the family. To this end, with funding from the John D. and Catherine T. MacArthur Foundation, researchers designed and validated the Adolescent Domestic Battery Typologies Tool (ADBTT) using the largest sample of adolescents charged with domestic battery on a parent to date. The goal was to determine if there are subtypes of classes of youths who would be best helped by different system responses, some of which may pose a risk for further ADB, whereas others may need only minimal intervention to assist the family. This brief will discuss the different categories of youths charged with ADB, how to assess them to make more informed decisions, and treatment approaches with the potential for success. Ideally, implementation of the ADBTT tool early in the juvenile justice process would lead to diverting the "right" youths away from formal justice processing with minimal intervention and would help derive the best treatment protocol within the system of care.

Significance and Scope of the Problem

Research estimates the number of adolescents who have hit their parents at least once as ranging from 3 percent to 20 percent (*Cornell & Gelles, 1982; Snyder & McCurley, 2008; Ulman & Straus, 2003*). However, it is difficult to derive accurate prevalence rates because there is wide variability in the way these offenses are recorded across jurisdictions. For example, a youth may be charged with an assault, and whether the assault was domestic is not recorded. Typical responses to ADB rely on the adult intimate partner violence model.

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State legislatures have increasingly passed statutes mandating that criminal justice officials pursue domestic violence offenders more aggressively. These laws were designed to reduce subsequent violence or prevent latent violence from surfacing (*Dugan, 2002*). Some of these statutes have resulted in mandatory arrest laws whereby police officers were mandated to arrest at least one individual deemed the primary aggressor (e.g., Alabama, Colorado, Connecticut, and Kansas; *American Bar Association, 2014*) when responding to domestic violence calls. This model favors a retributive or punishment-oriented approach that often involves separation of the parties and blame on the perpetrator. Police officers often use discretion in determining the primary aggressor and may choose to arrest the adolescent because removing them from the home is least disruptive to the family dynamic and can result in the diffusion of the initial event. These responses are not developmentally sensitive, can result in exposure to youths already struggling with delinquent behavior and/or violence, and fail to treat ADB as a multi-dimensional issue by focusing only on the adolescent. In addition, detention has been found to have a profound impact on adolescent physical and mental well-being (*Holman & Zeidenburg, 2013*). For youths who are detained for the first time and/or have never been identified as having a mental health need before system involvement, research has begun to show detention may be the cause of mental health stress or the onset of mental health issues such as depression and anxiety. Forrest et al. (*2000*) found that one-third of youth incarcerated experienced their initial onset of depression when first placed in detention. Tapia et al. (*2015*) indicated that youths and adolescents who were arrested for the first time scored more than twice as high for suicidal ideation than youths with a history of juvenile justice involvement.

In addition, in jurisdictions where the common response to ADB is to place the youth in a detention facility, this can place unnecessary strain on those facilities. In Illinois, for example, stakeholders found that despite 99 percent of ADB incidents resulting in no injury or only minor injury, adolescents were being placed in detention at nearly twice the rate of other adolescents charged with a crime and were formally processed by the court at higher rates (*Hartnett et al., 2012*).

A significant percentage of adolescents charged with ADB have been involved with child and family systems before coming into contact with juvenile justice, indicating the need for coordinated care. In a large sample of adolescents charged with ADB (N = 373) in six jurisdictions, it became apparent that many of the youths and families had multiple needs that would benefit from a coordinated system of support (*Nussbaum, Berry, Hartnett, & Vincent, 2015*). The majority of youths (68 percent) reported having received mental health counseling or a psychological evaluation in the past, and a little more than half (55 percent) reported receiving a mental health diagnosis at some point. Similarly, nearly 40 percent of youths reported that at least one person they live with had been diagnosed with a mental illness, which is likely an underestimate since another 20 percent said they were unsure. Twenty-five percent of the sample had prior or current child welfare involvement, but the rates varied widely across jurisdictions (45 percent of youths in Bexar County, Texas, compared to 3 percent in DuPage County, Illinois). Just under one-quarter of the youths reported having seen, heard, or known of someone in their home having been physically abused.

The MacArthur Adolescent Domestic Battery Typologies Tool Validation Study

The Adolescent Domestic Battery Typologies Tool (ADBTT) Validation Study was designed to examine characteristics of adolescents charged with assault on a parent or caregiver and to refine and validate an

assessment instrument that would identify different typologies or categories of youth with different needs. The notion that there may be different categories or types of adolescents charged with these offenses stemmed from years of clinical experience by a member of the research team (Wendy Nussbaum, LCPC) and preliminary data that the team had gathered on a sample of 100 youths from one jurisdiction. The study involved different types of juvenile justice personnel completing a pilot assessment instrument with youths and at least one caregiver referred to one of five courts in four states, resulting in a sample of 373 youths. The assessment was conducted at different entry points across the jurisdictions depending on their system, which promoted the use of a diverse sample and later generalizability of the findings. After eliminating or revising items with poor inter-rater reliability, factor analyses indicated there were four types or categories of adolescents, which varied significantly with respect to their presence of mental health issues, prior traumatic experiences, and other behavioral problems. The research team labeled and described the typologies as follows (*Nussbaum et al., 2015*):

- **Defensive (13.7 percent of the sample):** For this type, *any* violence (not just the current incident) directed toward the parent/caregiver had been in response to a physical threat by the caregiver. Girls were more likely than boys to fall into this category. This group had the highest rate of child maltreatment (according to the Juvenile Victimization Questionnaire – Sum Screener [JVQ]; *Finkelhor, Ormrod, Turner, & Hamby, 2005*), was the least likely to have had prior police contact and was the most likely to have a caregiver who abused alcohol or drugs and had hurt them out of anger. They also had the lowest rates of reported mental illness (34 percent).
- **Isolated incident (26.3 percent of the sample):** For this type, the aggression was an isolated event born out of atypical family or individual stress. Without such stress, the youth may have chosen a more appropriate conflict resolution. This group had the lowest rates of child maltreatment and any form of victimization. More than half had been exposed to a form of counseling or evaluation in the past (64 percent) or had been diagnosed with a mental illness (54 percent). For youths in this category, the parents/caregivers tend to have maintained appropriate levels of authority and encouragement of the youth and were surprised by the incident.
- **Family chaos (17.8 percent of the sample):** This type is characterized by a pattern of events in which the youth's behavior predictably spirals to the point of battery in order to obtain their purposes and is characterized by inconsistent and unclear parental authority, which also may be aggressive at times. For these youths, the aggression appears instrumental in nature; their behavior may continue to intensify until they get what they want, and then the aggression stops. A higher proportion of girls (21 percent) than boys (15 percent) appeared to fit this type, and these youths did not stand out from the others with respect to victimization, parental problems, or mental health needs. To translate these findings to community mental health, the Child and Adolescent Needs and Strengths (CANS) is a widely used assessment with at least 17 states having adopted state-wide implementation, and 27 states in the process of implementing it at a jurisdictional level (Coldiron, et. al., 2016). For those organizations using the [CANS] assessment, the comparable domain would be the constructs falling within the Life Domain. Depending on the adaptations of the site, scores on the Family Stress, Living Situation, and Involvement in Care constructs could be indicative of a youth who was at risk of or engaged in domestic altercations with their parents or siblings.
- **Escalating (42.2 percent of the sample):** This was the most common type, characterized by a pattern of behavior designed to intimidate, control, and coerce the parent into giving in to the youth's demands, ultimately establishing the youth in a position of control over the parent. The parents may eventually give up authority out of fear. Youths in this type received the highest scores on the JVQ (indicating

they had the highest rates of general victimization), and had the highest rates of histories of mental health treatment (72 percent), and prior contact with police (77 percent).

With respect to re-offending, the escalating and family chaos types had significantly higher rates of new petitions for another act of domestic assault over an average 10-month follow-up (31 percent and 33.8 percent, respectively) than the isolated incident (16.7 percent) or defensive (14 percent) youth.[1] The escalating type (53.9 percent) was the most likely to have committed new offenses in general.[2] The typologies from the ADBTT were a significantly better indicator of who was likely to commit another act of domestic assault than the validated general risk assessment tools used within each jurisdiction in the study.[3]

Conducting the ADBTT

Use of the ADBTT provides the basis for recognizing that not all youths who commit domestic battery have the same risk level to re-offend or the same level of need for intervention. There is considerable variation with respect to the family dynamic and how much intervention is needed with the family unit. The ADBTT was designed as a predispositional assessment instrument for use in juvenile justice settings at the time of arrest, upon admission to detention, in alternative domestic violence or crisis center settings, or as part of the court or probation intake process. It is completed by conducting an interview with the youth and the family and gathering all essential collateral information. The evaluator rates the youth and family along eight items, which are defined in the manual (*Nussbaum et al., 2015*).

The ADBTT also would be helpful for use in other related clinical and social service settings that deal with family violence, such as crisis centers, community mental health/family counseling agencies, and child welfare settings. Therefore, its applicability cuts across child-serving systems within a system of care. Regardless of which agency conducted the assessment, the youth and families will benefit from the appropriate sharing of information about the youth and family's ADB type, dynamic, and underlying concerns that would be the best targets for services and supports.

Inventions and Treatment of ADB

A system of care (SOC) is a coordinated network of community-based services and supports organized to meet the challenges of children and youths with serious mental health needs and their families (*Pires, 2010*). By definition SOCs should modify existing delivery and support systems to better align with the needs of families struggling with ADB. While keeping in mind that governmental structures are primarily categorical with distinct mandates, missions, staffing requirements, funding streams, and accountability (*Pires, 2010*), a community using the SOC framework should navigate around and through those categorical barriers to better coordinate services and supports. The ADBTT, along with other information such as mental health assessments, can guide policy makers and providers on development and support of the SOC needed for each youth and their family. The goal is to effectively match the intensity and nature of intervention with the youth and family, their level of risk for further ADB, and the home dynamic, while balancing community safety with the needs of the youth and family.

The ADBTT manual provides an example of a continuum of treatment response options by ADB type, which requires system of care coordination and primarily community-based strategies. Ideally, the juvenile justice and service provider agencies would partner on the completion of a matrix of coordinated treatment response options to maximize the effectiveness of interventions. For example, those in the defensive type may require education and therapeutic intervention for the parent,

[1] χ^2 (3, 365) = 12.57, $p < .001$.
[2] χ^2 (3, 365) = 24.86, $p < .001$.
[3] LR test = 35.683(3), $p < .001$

combined with safety planning and individual counseling for the youth. Those in the escalating type would require more rigorous treatment for the whole family such as the Step-Up program (a 21-week group therapy curriculum with a parent component). The ADBTT should be supplemented with mental health screening and, if applicable, mental health assessment as well as screening for exposure to potentially traumatic events. Community services and supports for mental health or trauma, in addition to parent education or targeted domestic aggression interventions, may be essential. Youths in the escalating type seem to have the highest likelihood of having these multiple needs.

Summary

There is a shared desire across child-serving systems to reduce youth involvement in the juvenile justice system. Use of the ADBTT to inform intensive care coordination to create access to appropriate services and supports could be an opportunity to avoid exposure to or further involvement in the juvenile justice and/or child welfare systems. This is particularly relevant for youths in the defensive, isolated incident, or family chaos types. Youths in the escalating type are more likely to require involvement with the juvenile system because they are most likely to have generalized patterns of delinquency requiring treatment of their criminogenic needs. Understanding the underlying needs driving domestic violence are often complex and pose challenges for policy makers, service providers and families, addressing ADB will require a coordinated system of care that understands and addresses the youth's most prominent criminogenic risk factors (e.g., substance abuse, negative peer relations, attitudes that condone crime or violence) in conjunction with the ADB treatment protocol. Some recommended strategies around interventions for youths charged with ADB within a system of care are:

- Agencies and other partners in the system of care should all be involved in the development of a treatment response protocol in line with the youth's ADB type.
- Through the SOC framework, agencies and other partners closely collaborate to provide appropriate, effective services and supports to address specific issues.
- The treatment response protocol should include a clear pathway for assessment and access to the appropriate supports/referrals for the youth and family for the youth's ADB type.
- The ADBTT should be supplemented with behavioral health and potentially trauma screening, followed by appropriate assessments if indicated.
- If an agency is using the ADBTT, it should educate other providers within the SOC on its use and the definition of ADB types. As a part of the treatment response protocol development, communities should involve all partners within the SOC in aligning language around risk for future ADB category and assessment criteria for appropriate treatment, services, and supports.

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