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Assessing Future Violence Risk in Transitional Age Youth: Challenges, Limits, and Clinical Realities

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Transitional aged youth (TAY) is a term originally coined by the foster care system to describe individuals aged 16–25, a developmental period spanning late adolescence through emerging adulthood. The American Psychiatric Association published a position on TAY in 2024 stating that this developmental period is a critical time in one's life where many mental illnesses initially present or worsen. (1) This stage is characterized by rapid neurological maturation, shifting social roles, identity formation, and increasing independence. In forensic and clinical psychiatry, TAY frequently present with first-episode psychiatric illness, evolving personality structure, and unstable psychosocial supports; all of which complicate violence risk assessment. Yet despite their developmental distinctiveness, TAY remain poorly represented in structured violence risk research. They are often evaluated using tools designed either for juveniles or fully mature adults, leaving clinicians without a developmentally precise evaluation tool.

Neurodevelopmental research has unequivocally demonstrated that the human brain continues to mature well into the mid-20s, particularly in regions governing executive function, impulse control, and emotion regulation. (2) During the TAY period, the prefrontal cortex is still undergoing synaptic pruning and myelination being one the last areas of the brain to develop. (2,3) Consequently, until the prefrontal cortex is fully developed studies have shown that this age group relies on the limbic system to make decisions, resulting in decisions heavily influenced by emotions instead of reason. (2) This developmental timeline explains why TAY demonstrate heightened sensitivity to peer influence, increased risk-taking, and poor decision-making capacity. Adolescents under age 18 typically have even less developed regulatory systems, while fully mature adults show greater integration between emotional and executive networks. These differences amongst these distinct life stages leave TAY with a greater risk of engaging in crime versus the younger adolescent and older adult population. (2,4)

Despite the developmental distinctiveness of TAY, there are currently no validated violence risk assessment tools designed specifically for this age group — especially for those without a criminal history. Most instruments used in practice today were developed for either adolescents or adults. Adolescent tools such as the SAVRY and YLS/CMI emphasize developmental risk factors, peer influences, and school-based

behaviors, often reflecting profiles of delinquency or justice-involved youth. On the opposite side, adult instruments like the HCR-20, VRAG, and PCL-R rely heavily on historical variables such as past criminal behavior, patterns of offending, and long-term antisocial traits that are largely absent among TAY with no prior legal contact. Consequently, these tools may either underestimate risk because of insufficient historical weighting or overestimate normative developmental behaviors by using mature adult criteria to assess risk. Thus, clinicians attempting to assess future violence risk in TAY often confront a dilemma: to use tools that do not fit the developmental context or rely on unstructured clinical judgment with its attendant biases and variability.

The need for a specialized violence risk assessment tool in the young adult population is demonstrated by a recent case in Bartow, Florida. On May 17, 2025, 19-year-old Moses Ojeda, who had no prior criminal history and no known history of previous violent aggression, fatally stabbed an elderly resident of a group home just hours after discharge from an inpatient psychiatric facility. As per public information, Ojeda was discharged after a two-week inpatient admission without what appears to be an appropriate discharge plan. This was his sixth involuntary psychiatric evaluation since January 2025 according to news outlets. (5) Ojeda was discharged and picked up by his mother from the hospital, who then took him to an Adult Family Care Home (AFCH). According to media outlets, there was “miscommunication” about Ojeda’s diagnoses to the AFCH. (6) Shortly after discharge on May 17, 2025, Ojeda reportedly experienced symptoms of psychosis. Ojeda told police that “voices in my head told me to kill him”—red flags that would likely have been missed by current violence prediction tools as they do not take into account current psychiatric symptoms rather focusing on historical factors. Despite his lack of a criminal record, Ojeda reportedly had some domestic battery incidents with his mother. (7,8)

Currently, there is no effective or reliable tool for violence assessment specifically for the 18–24-year-old population prior to hospital discharge from a mental health facility. With the current available tools, violence risk assessment for this particular age group may produce a deceptively low score due to the absence of prior violence or criminal history. A study evaluating the HCR-20 in individuals experiencing first-episode psychosis found that many patients were incorrectly rated as low risk despite exhibiting key clinical features associated with violence, such as persecutory delusions or command hallucinations. (9) The predictive validity of such tools in youth with no criminal history is consequently limited, as they may not flag cases with a high clinical severity of illness and criminal history.

Our growing clinical and research experience has prompted us to consider what a TAY-specific violence risk assessment tool should include. Such an instrument would need to reflect neurodevelopmental status, executive function capacity, and contextual stressors unique to transitional life phases amongst other factors. Integration of structured clinical

judgment with empirically weighted developmental factors could enhance both predictive validity and clinical utility.

Accurately assessing future violence risk in transitional aged youth remains a significant challenge in forensic psychiatry. The developmental distinctiveness of this population and the limitations of existing tools necessitate dedicated research and tailored assessment strategies. By developing a risk assessment tool tailored to the TAY population, we can better identify violence risk, implement appropriate interventions, and uphold both public safety and the fair treatment of TAY within clinical and legal systems.

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