

Progress and Perils in the Juvenile Justice and Mental Health Movement

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The juvenile justice system in the United States is experiencing a social movement aimed at responding to the mental and emotional problems of delinquent youths. Ironically, this movement arose in the wake of a decade of reform in juvenile justice that had set aside the system's 100-year tradition of rehabilitation for delinquents in the interests of their punishment and a primary emphasis on public safety. This article describes the recent juvenile justice and mental health movement, discusses the circumstances that motivated it, and provides examples of its progress. Now that the movement has taken hold, however, its future is threatened by several unintended consequences of the motives and strategies of those who succeeded in promoting the movement. Those potential perils are described with an eye to reducing their impact, thereby sustaining the movement and its potentially positive effects.

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More than at any other time in its history, the juvenile justice system is the focus of extraordinary nationwide efforts to address concerns about the mental health needs of delinquent youths. The purpose of this article is to identify this phenomenon as a social movement, to describe how it developed, and to examine its progress and its perils.

In 1995, whether one was reading newspapers or articles in criminology journals, the portrayal of delinquent youths was frightening. Homicide and aggravated assaults among teenagers had more than doubled between the late 1980s and early 1995.¹ Projections by one leading criminologist predicted “a blood bath” by 2005.² The prevailing image of the new delinquent was that of a ruthless “super-predator” capable of cold-blooded murder.³ The nation accepted the notion that somehow, almost overnight, delinquent youths had changed, rendering our century-old rehabilitative approach to juvenile justice no longer appropriate.

This perception fueled a frenzy of lawmaking that some have called a “moral panic.”⁴ In only a few years, almost all states adjusted their juvenile laws to fit this image of the new juvenile super-predator.⁵ The political bumper sticker for the new response to delinquency read very simply, “Adult time for adult crime.” The new laws were designed to guarantee that a larger number of youths, at younger and younger ages, charged with a wider range of major and minor offenses, would be tried in criminal court as adults.⁶ Thus, between 1987 and 1994, the number of youths transferred by juvenile court to criminal court nearly doubled.⁷ If youths stayed in juvenile court, new laws guaranteed that often they would face harsher sentences than before, emphasizing discipline and deserved punishment. If possible, they would be handed over to adult prisons at the end of their juvenile sentences. In many states, “public safety” replaced “rehabilitation” in the official purpose clauses of reformed delinquency statutes. We seemed to want a juvenile justice system that would protect us from our own children, not simply by getting them off the streets, but by getting rid of them for the rest of their lives. Gone was a 100-year-old tradition that dealt differently with youthful offenders than with adults, based on the notion of youths' less-mature developmental status.

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That was 1995. Yet within only a few years, juvenile court observers began to sense a change. There is the story, for example, of a meeting in the late 1990s of juvenile correctional administrators, at which they were asked about the three most pressing problems that they should work on to improve juvenile corrections. Apparently, one of the veteran administrators gave the following response. “The three most pressing issues,” he said, “are mental health, mental health, and mental health.”

His astonishing answer reflects a new wave of concern heard in many quarters by 2000. The U.S. Surgeon General declared a mental health crisis among youths entering the juvenile justice system.⁸ Across the United States, juvenile correctional administrators acknowledged that their facilities had become *de facto* psychiatric hospitals and they were trying to find ways to identify youths’ mental disorders as they entered detention centers. In the middle 1990s, the Office of Juvenile Justice and Delinquency Prevention was funding boot camps for youths, but by 2000 it was waging a campaign to get juvenile justice facilities to identify youths’ mental health needs and respond to them.

What happened in that short span of about five years? How did the nation’s image of delinquent youth suddenly change from cold-blooded, budding psychopaths deserving banishment to troubled and immature youth in need of clinical services?

One event was a dramatic annual decrease in the rate of serious violent offending by youths between 1995 and 2000.⁹ The public was relieved, and perhaps everyone stepped back to reconsider the wisdom or necessity of the new get-tough laws that now dominated our response to delinquency. What emerged, though, was not simply a return to the past, but what appears to be a juvenile justice and mental health movement that is reforming society’s response to juvenile offenders.

Later, this movement’s evolution and some of its positive outcomes are described. But not all of its consequences have been salutary. The image of the delinquent as super-predator has been replaced by the troubled delinquent—a youth who meets criteria for one or more mental disorders and who is in need of treatment. Many will see this as progressive, but it has its risks as a foundation for juvenile justice reform. Zealous advocacy to respond to youths’ mental health needs is important to improve mental health services for youths in juvenile justice custody, an ob-

jective that almost everyone now agrees must be met. But zeal without the balancing effect of careful thought about how to accomplish that objective can do more harm than good. The potential perils of this movement, therefore, must be recognized and studied, to avoid them and to steer a careful course toward effective mental health services for delinquent youths. After recounting the movement’s successful start, this article describes three types of peril that threaten its future. The following description of the progress and perils of the juvenile justice and mental health movement is offered from a U.S. perspective. The movement apparently has not arisen with as much force in other countries, although researchers in Great Britain, the Netherlands, and Belgium have begun to identify similar trends and issues in juvenile justice settings in their countries.

The Progress

The first signs of change arose in the late 1990s and grew rapidly in the recent half-decade. An early benchmark for the movement was a monograph published in 1992 by the National Coalition for the Mentally Ill in the Criminal Justice System.¹⁰ Edited by Joseph Cocozza, this collection of writings by researchers and clinicians summarized what we knew at that time, which was very little, regarding the prevalence, identification, and treatment of mental disorders among youths in juvenile justice settings. The work stimulated some key people who later helped to fuel the movement and has been widely cited in recent years as an early call to arms. Unfortunately, it came at a time when youth violence statistics were beginning to soar, and therefore it had to compete with the strong voices of policy makers bent on simply locking youths away.

Social Context of the Movement

Several coincidental social circumstances of the 1990s contributed to the start of the movement. One was the practical effects of the recent punitive legal reform. It was becoming apparent that the nation’s get tough policies were creating substantial overpopulation of juvenile justice facilities. In addition, staff of those facilities began reporting what they thought was an alarming increase in the influx of youths with behavior that looked to them like mental health problems, contributing further to chaotic conditions for youths and staff in secure facilities. By then it was also apparent that during the early 1990s there had

been a nationwide deterioration in state funding for child community mental health systems. State after state had experienced the collapse of its public mental health services for youths, some states having closed all of their residential facilities for seriously disturbed adolescents (e.g., Ref. 11). Together, these circumstances raised suspicions that the new punitive laws, coupled with inadequate public mental health resources for youths, were beginning to turn the juvenile justice system into a place to deposit youths who could no longer get help in the community.

Other circumstances of a more academic nature provided conditions favorable to the start-up of a mental health movement in juvenile justice. During the 1980s, child clinical psychology and pediatric psychiatry witnessed the evolution of a new conceptual approach called “developmental psychopathology.”^{12,13} Its principles freed child clinical studies from a tradition heavily burdened by presumptions based on adult psychopathology. By the 1990s, this new approach was promoting advances in ways to conceptualize and measure mental disorders within the context of adolescence as a developmental period, including the relation of these disorders to youths’ aggressive behavior. The change in direction opened up new explorations of adolescents’ mental disorders and meaningful ways to classify and measure them.

Three Ingredients for the Movement’s Launch

In response to these conditions, three key ingredients for a juvenile justice and mental health movement began to emerge in the late 1990s: research, advocacy, and financial incentive.

Concerning research, several projects that started from 1992 to 1996 eventually played a major part in providing an empirical basis for the movement. For example, Teplin and colleagues¹⁴ had begun a study that eventually would produce the first solid evidence of the prevalence of mental disorders among youths in juvenile detention centers. Wasserman and colleagues¹⁵ and Grisso and Barnum¹⁶ were developing special assessment tools to allow juvenile justice personnel to identify youths with mental health symptoms and to obtain tentative diagnoses as the youths entered juvenile detention or corrections facilities. Other researchers, including Henggeler *et al.*,¹⁷ were beginning to lay the empirical foundations for community-based treatments for delinquent youths that

would eventually offer evidence-based and cost-effective alternatives to incarceration.

The second ingredient was an increase in child advocacy within juvenile justice by government agencies and private foundations. The decision makers began to recognize the possibility that the punitive excesses of the recent juvenile legal reform were ignoring, or even contributing to, the mental health problems of youths. For example, in the late 1990s when the homicide rates among adolescents began to decline, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) began exploring the need for government attention to the conditions of pretrial and correctional secure facilities for juveniles.¹⁸ The MacArthur Foundation initiated a research network on Adolescent Development and Juvenile Justice, with a mandate for research on the relevance of delinquent youths’ developmental characteristics to their adjudication and care.¹⁹ The Annie E. Casey Foundation launched its Juvenile Detention Alternatives Initiative, involving a strategy to work directly with interested juvenile justice programs to increase the diversion of youths from juvenile justice processing in favor of community-based services.²⁰ In addition, a national network of juvenile law centers began driving home to juvenile defense attorneys the importance of attention to youths’ mental health needs while advocating for juvenile defendants (e.g., Ref. 21). In 2000, that call was joined by appeals from OJJDP,²² the National Council of Juvenile and Family Court Judges,²³ and the National Mental Health Association.²⁴ As they began working together, all of these advocates were capable of creating a good deal of media attention and sustaining momentum.

The third ingredient was financial incentive. Late in the 1990s, the Department of Justice began a series of investigations of several states focused on conditions of juveniles’ confinement. (For examples of Department of Justice investigations of juvenile justice programs of the late 1990s and early 2000s, see the information pertaining to Arizona, Louisiana, Georgia, and Florida in Ref. 25.) They found facilities overcrowded as the result of the get-tough policies of the 1990s and understaffed by private companies that ran juvenile facilities as though they were adult prisons. Litigation in these states often resulted in consent agreements requiring the investment of millions of dollars and a promise of continuing effort

for improvement, often targeted in part for responses to delinquent youths' mental health needs.

In addition, the federal government developed a program of juvenile justice block grants for which states could apply if they developed and proposed plans for improvements in their response to youths' health and mental health needs.²⁶ Each state was required to develop a State Advisory Group to steer the use of block grant funds, and often those advisory groups targeted screening, assessment, and mental health responsiveness in juvenile facilities. Added to this were substantial sums of money earmarked for juvenile justice reform that began to be available to states through private organizations such as the MacArthur Foundation and the Casey Foundation. By 2000, it was not unusual to find states with juvenile justice agencies that suddenly had many millions of dollars added to their budgets annually, much of that for improving the mental health care of juveniles in their custody.

Thus, by 2000, it was clear that change was under way and was progressing with a sense of urgency. Juvenile justice systems were required to reform, and the money available to do it offered them a rare opportunity for system improvement if they could respond to the challenge. The research that began in the 1990s was ready to fuel the movement, providing evidence that up to two-thirds of youths in juvenile justice facilities met criteria for one or more mental disorders.¹⁴ Identifying those youths became a high priority for those reforming juvenile justice systems. Many new tools to screen and assess juvenile justice youths for mental health needs had just been made available, and the juvenile advocacy foundations were providing the energy and media attention. (For reviews of over 20 of those instruments, see Ref. 27.)

An example of the potent effects of this mix of research, advocacy, and funding can be seen in the rate of adoption of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), developed by Grisso and Barnum^{16,28} in the 1990s. The MAYSI-2 is a youth self-report tool designed specifically for use at the front door of juvenile pretrial detention centers or juvenile correctional programs. It is not diagnostic, but in a 10-minute procedure that does not require a clinician, it allows detention staff to identify whether youths are reporting clinically significant levels of symptoms on six dimensions, such as suicide ideation and depressed or anxious affective conditions. It signals the need for

immediate emergency clinical consultation or further clinical assessment.

Development of the MAYSI-2 began in 1994, at a time when few administrators saw the need for a mental health screening tool. With support from the William T. Grant Foundation, the instrument was developed, validated, and readied for release in 2000. Funding by the MacArthur Foundation provided technical assistance to states willing to adopt and implement the tool routinely with every youth entering juvenile facilities. The juvenile justice and mental health movement was just beginning, and a few progressive states were ready to adopt the MAYSI-2 for use statewide in some parts of their juvenile justice systems—for example, all detention centers or all juvenile correctional programs. Those states with statewide use numbered 7 by 2001, but they grew with astonishing speed to 20 by 2003 and to 38 by 2006. In the 1990s, if a detention center was doing mental health screening, it usually consisted of two or three questions that a staff member had thrown together. Now, just a few years later, a probable majority of juvenile detention centers in the United States routinely employ the MAYSI-2 or some other standardized, validated mental health screening tool.

This readiness to adopt methods and tools associated with mental health and rehabilitation in juvenile justice was not confined to mental health screening. For example, Multisystemic Therapy, a community-based intensive system of behavioral and social assistance to youths and families, was being adopted widely across the U.S. Staff of such organizations as the National Center for Mental Health and Juvenile Justice²⁹ found themselves almost continually responding to juvenile justice systems that were looking for effective ways to provide mental health services for youths in their custody. The MacArthur Foundation's new initiative, *Models for Change: Systems Reform in Juvenile Justice*,³⁰ was welcomed by four states that pledged to use the Foundation's resources to make sweeping reforms in their juvenile justice programs, with the intention of producing developmentally meaningful models for satisfying society's rehabilitative, safety, and due process objectives for juvenile justice.

Early Consequences

The next question, of course, is whether these developments are doing any good. There is ample evidence of the change itself and a growing body of

literature focusing specifically on the mental health needs of youths in juvenile justice settings.^{27,31–33} The Casey Foundation's Juvenile Detention Alternatives Initiative has solid evidence that conscientious adherence to the diversion strategies that it promotes has cut the census of many detention centers in half. (For articles describing outcomes related to the Initiative, see Ref. 20.) Solid and repeated documentation of reduced recidivism as a result of multisystemic therapy at much lower costs than incarceration has been published.¹⁷ Research on the impact of mental health screening is beginning to yield evidence that staff knowledge of youths' mental health needs is resulting in safer detention environments. There have been substantial reductions in infractions in detention that result in violent incidents and reductions in imposition of seclusion and restraint in detention.³⁴

Yet studies of some detention sites have suggested that better mental health screening does not necessarily lead to increases in actual referrals of youths for further clinical assessment or psychiatric services.³⁵ While identification of youths' needs has clearly improved, we do not yet have good evidence that the ultimate objective has been achieved: better mental health care for youths in juvenile justice custody.

Moreover, there are some signs that the movement, having made a dramatic takeoff, may be encountering turbulence. Many social movements begin with a zealous surge of advocacy. The first stage of a movement is often aimed more at gaining initial momentum than at charting a safe course for the long run. Perhaps most social movements in their early stages are, like many youths themselves, motivated more by immediate gains than by careful attention to longer-range risks. This drawback may explain some disturbing things observed by this author and other consultants while advising juvenile justice facilities nationwide regarding their adoption of mental health screening for youths in custody. What they have observed are unanticipated effects of the efforts to increase identification of youths with mental health needs that may not be in the best interests of the youths. The remainder of the article presents observations of the author during clinical and research consultation with juvenile justice programs in recent years, as well as concepts developed in an earlier work.³⁶

The Perils

The present juvenile justice and mental health movement bears the marks of three types of potential risks of negative consequences: translational risks involving overinterpretation of the message, economic risks of bandwagon incentives, and systemic risks that may result in iatrogenic injustice.

Overinterpreting the Message

The movement was energized by empirical evidence offered by many reliable studies that provided data about the prevalence of mental disorders among youths in juvenile justice settings. Those studies announced that a large proportion of these youths—as many as two-thirds—met DSM criteria for one or more mental disorders (i.e., mood, anxiety, substance use, conduct, or developmental disorders). This was an alarming message for many juvenile justice administrators. Federal government and juvenile advocates called for the juvenile justice system to respond and many presumed that this meant that they had to find a way to provide treatment for most of the youths in their care.

This presumption, of course, is simplistic. The fact that two-thirds of youths in detention centers meet criteria for a psychiatric disorder does not mean that they are seriously in need of psychiatric treatment. Youths with a particular disorder vary in the severity of their symptoms. Some function relatively well in everyday life and others very poorly. Youths' psychological conditions are more labile than those of adults. Compared with adults, there are greater risks that youths with symptoms of one disorder at one point may, within another year, meet criteria for a different disorder or no disorder at all. Moreover, prevalence rates for mental disorder depend on what one defines as mental disorder. Shall we leave in or take out conduct disorder? How about substance use disorders? Thus, most experts recognize that it is not necessary and is probably unwise for the juvenile justice system to translate the published prevalence rates into a policy that seeks treatment for two-thirds of the youths in its custody.

Juvenile justice personnel, however, often did not recognize the difference between diagnosis and treatment need. There were at least two negative reactions by juvenile justice personnel to these overwhelming statistics. One was paralysis. The thought of providing treatment for such a large number of youths seemed to some so daunting that they failed to re-

spond at all. The perceived magnitude of the problem seemed to defy the development of a plan. The other reaction was resistance to the use of mental health screening at admission to their facilities. Some administrators feared that this would document a level of need for treatment to which they could not possibly respond, thus providing evidence for lawsuits if they did not fulfill a mandate to provide adequate mental health care for youths in their custody.

Another problem in translation of the message about prevalence was the tendency for laypersons to make assumptions about a relationship between youths' mental disorders and aggression. Learning that most youths arrested for aggressive behavior meet criteria for a mental disorder, juvenile justice personnel sometimes translated this into conclusions such as, "Aggression is due to mental disorder," or "Treating youths' mental disorders will reduce aggression."

There are good theoretical reasons and some empirical ones to believe that some mental disorders do include symptoms that increase the risk of aggression in youths: for example, the impulsiveness brought on by attention deficit hyperactivity disorder (ADHD) and the hypervigilance caused by PTSD, or the anger that frequently accompanies depression in youths.³⁷ But this does not mean that all or most illegal aggression by youths is due to mental disorder. It does not even mean that all aggression by youths with mental disorders is caused by symptoms of their disorders. Moreover, without careful explanation the prevalence of mental disorders among delinquent youths creates public fear of these youths, even though most are not aggressive.

In summary, using the high statistics for prevalence of mental disorders among delinquent youths to arouse attention to their needs is understandable as a motivational strategy, but without further translation, it can have troubling negative consequences. It can cause presumptions that inflate our estimates about necessary resources to meet the problem, based on the mistaken notion that all troubled youths need treatment. Conversely, the thought of trying to treat them can inhibit rather than encourage action on the part of some juvenile justice personnel. Untranslated, the statistics also can contribute to negative misperceptions about youths with mental health problems. Part of the remedy is to include some of the interpretations within the basic message. For example, if we are describing the prevalence of disor-

ders among delinquent youths, we must balance that with an estimate of those with serious or emergency needs, which is certainly far lower than two-thirds of youths in juvenile justice settings. (Evidence for this assumption is detailed in Ref. 36, pp 57–80.)

Bandwagon Incentives

Another set of risks for the juvenile justice and mental health movement has been the unintended effects of a system of incentives that arose to encourage reform. As described earlier, federal agencies and state government initiatives promoted attention to mental health problems among delinquent youths by providing substantial financial assistance to juvenile justice administration to address those concerns. When this was in the form of federal grants and state funding driven by the threat of suits, it often imposed deadlines for compliance with demands for mental health screening, assessment, or treatment services.

The consequence was a sense of urgency among juvenile justice administrators, not merely to do something, but to do it immediately. Political pressure to comply sometimes caused administrators to take quick action that sacrificed the details for the deadline. For example, regarding mental health screening for juvenile justice facilities, sometimes administrators did not carefully consider what methods were appropriate; what decisions should and should not be based on those methods; whether the information should or should not be shared with others inside or outside their agencies; whether a pilot process might be helpful; or how, when, and by whom mental health screening tools should be administered.

Observations of juvenile justice systems' implementation of the MAYSI-2 provided several examples of the effects of haste or lack of attention on the integrity of the tool for mental health screening in detention centers. Sometimes this gave rise to practices that completely invalidated the instrument's use. For example: Seeking greater efficiency, one state developed a new MAYSI-2 answer form. It eliminated the "no" answer column and reorganized the standardized random appearance of the items so that they were grouped according to scale, then labeled the groupings on the answer form (so, for example, the youth read "Depressed-Anxious" before answering the items that contributed to that scale).

Given the instructions that "every youth must be screened at admission," a detention center adminis-

tered the MAYSI-2 to youths every time they reentered the unit—after court appearances, doctor’s appointments, and visits with parents. Some youths were receiving the MAYSI-2 several times a week and simply began circling all the “no’s” on the screening tool. Whereas “all no” responding on the MAYSI-2 is less than 10 percent in most facilities, it was 40 percent in this one.

In one site, a pilot study showed that the proportion of youths above cutoff was higher in that facility than the average for facilities nationwide. The administrators changed the cutoff scores to bring their institution’s proportion more in line with the national average.

Some juvenile courts were using MAYSI-2 scores or other 10-minute screening measures as their primary source of data for making long-range treatment decisions after youths were found delinquent, despite clear warnings on these instruments that they are neither diagnostic nor valid for deciding youths’ long-range needs.

It is quite likely that these inappropriate practices arose because juvenile justice administrators, many of whom were not accustomed to employing standardized methods, were pressed to make decisions about implementation of mental health screening too quickly. Getting on the national bandwagon to meet the demand to implement screening may have overridden careful thought or consultation on proper practices. In the case of the MAYSI-2, the availability of free consultation and technical assistance (through a clearinghouse supported by the MacArthur Foundation) was advertised and often known by juvenile justice programs that implemented MAYSI-2. Many programs availed themselves of those services and implemented mental health screening appropriately. But some agencies simply acquired the tool and, within a few weeks, put it in place under pressure to get it done.

The most obvious lesson in this experience is that the transfer of technologies—in this case, offering mental health measures to juvenile justice programs—must be accompanied not merely by incentives to implement them, but by incentives to implement them correctly. Especially when clinical methods are being used by those who are not mental health professionals, incentives must be in place to encourage them to seek guidance and make thoughtful decisions regarding the choice of assessment or treatment methods, as well as their

proper implementation. Without such incentives, zealous exhortations intended simply to motivate juvenile justice programs to adopt these procedures can be dangerous. In the present movement, too often the message was, “Just do it,” rather than, “Do it right.” If the program is not implemented correctly, the result can sometimes be worse than doing nothing.

Iatrogenic Injustice

The juvenile justice and mental health movement has been driven by two types of advocates. Some are child mental health advocates who saw a need for improved mental health services for youths in juvenile justice custody. Others are juvenile defense advocates who saw attention to the mental health needs of youths as a way to counteract perceived injustices, specifically, consequences of the punitive movement that had dominated juvenile law for several years. They presumed that a mental health agenda could serve to improve justice for youths who increasingly were being prosecuted as though they were adult criminals, despite their developmental differences and mental disabilities.

This has given rise to a peril that might best be called “iatrogenic injustice.” An iatrogenic disorder is one that is caused by treatment. Similarly, using mental health concerns to correct injustices sometimes can create other kinds of injustices.

The most troubling risk in this category of perils is that of turning the juvenile justice system into the nation’s mental health system. As noted earlier, just as the movement was beginning in the 1990s, almost all states were experiencing deterioration of their community child mental health services. This was the consequence of changes in state budgets, patterns of managed care, and a child deinstitutionalization movement. At about the same time, juvenile justice personnel began noticing that their detention centers were admitting a greater number of youths with serious mental health problems. By 2000, news articles began to describe mothers who were getting their children arrested so that they could access mental health services through the juvenile court that they could not obtain otherwise in their communities (for example, Ref. 38). A federal survey indicated that many communities nationwide were using their detention centers as places to park youths while they awaited psychiatric hospital beds, even if the youths

had not engaged in any actions for which they could be arrested. (A report of the results of a federal government survey of 19 states in which 12,700 youths were in juvenile justice facilities solely to get mental health services may be found in Ref. 39.)

If the juvenile justice system continues to be the community's link to mental health services that otherwise are very hard to obtain, the risk will increase that some youths will be processed on delinquency charges merely to get services, at the cost of a delinquency record that will have later negative consequences for them. The long-range solution, of course, is to improve community mental health services for children. But the pressure to do so is relieved if the juvenile justice and mental health movement itself creates a social milieu in which the community expects juvenile justice to shoulder the community's responsibility for managing youths' mental health needs. Even innovations that seem like creative solutions to the problem need to be examined carefully in this regard. For example, within the past two years, we have seen the development of a new kind of juvenile court called the "juvenile mental health court," with special features designed to deal more therapeutically with young offenders who have mental disorders.⁴⁰ If we do not proceed carefully with this innovation, might it merely become a magnet that draws those youths into the juvenile justice system, increasing their arrests and frequency of detention and adding to their delinquency records?⁴¹

The second risk of iatrogenic injustice is raised by competing roles of juvenile justice. Juvenile courts have an obligation to care for the health and mental health of youths in their custody, but they also have an obligation to prosecute juveniles, satisfy their victims, protect the community from offenders, and assure that they are punished. Beneficence and retribution have presented difficult, competing, objectives for the juvenile justice system throughout its history. The juvenile justice and mental health movement offers the latest variation on that theme.

For example, when mental health screening tools such as the MAYSI-2 are used at detention intake, typically the screening tool asks youths to self-report their behavior and feelings, such as their use of illegal substances, their angry feelings toward others, and various symptoms that increase the risk of aggression. That information is necessary to provide for youths' emergency mental health needs and immediate safety. But what are the risks that this same informa-

tion might be used to increase the likelihood of their transfer to criminal court, to prosecute them, or to increase their sentences? The circumstance arises in the treatment arena as well. Urged to meet youths' treatment needs, some pretrial detention centers have implemented anger management programs and group counseling activities. But by what authority does the juvenile justice system engage individuals in intrusive psychological treatment before adjudication, or acquire information in an unprivileged relationship in the guise of therapy, which may be subject to subpoena and used to convict them?

These are not hypothetical questions. As mental health screening has been implemented nationwide, detention centers sometimes have been asked by juvenile courts to send mental health screening results to the prosecutor's office as a routine procedure. Defense attorneys sometimes have objected to mental health screening of youths for fear that youths' responses could provide self-incriminating information for their prosecution.

These threats of iatrogenic injustice, creating legal jeopardy for youths in the name of beneficence, can be avoided if they are recognized early in a system's reform efforts and made the focus of preventive policy. For example, judges can establish court policies that prohibit the use of mental health screening information for purposes of adjudication. Screening can be used to divert youths from the juvenile system rather than encouraging their further penetration of it. Most of the dangers are avoidable if we recognize and confront them thoughtfully. But history is replete with examples of beneficent intentions that create injustice, a danger we face if we respond to juveniles' mental health needs by turning juvenile justice facilities into psychiatric units. Elsewhere, I have provided an analysis of ways to limit the treatment obligation of the juvenile justice system, while strengthening the obligation within those narrower boundaries (Ref. 36, pp 127–60).

Conclusion

The rather sudden appearance and rapid growth of the juvenile justice and mental health movement is both encouraging and troubling. It has created extraordinary consensus in juvenile justice regarding the importance of attending to youths' mental health needs, and it is putting in place many of the tools to identify and respond to youths' mental disorders. But those attitudes and practices will not long survive

if their adoption alone is seen as the successful conclusion. Sustaining the gains requires assisting juvenile justice to use mental health screening and implement services in ways that will avoid potential negative consequences of the movement.

It is too early to know the actual meaning of this movement in the context of the juvenile justice system's 100-year history. Is it merely an adjustment of the current system, or is it part of a more fundamental reform?

Juvenile justice policy in the United States has had three eras. The first was the birth of the juvenile justice system at the beginning of the 20th century. The second was the due process reform of the system represented by *Kent v. U.S.*⁴² and *In re Gault*⁴³ in the 1960s. Both of those eras arose after decades of growing consensus regarding their necessity. In comparison, the third, punitive reform of almost all states' juvenile laws in the early 1990s, evolved not gradually but almost overnight, as an immediate reaction to public fear when confronted by a sudden rise in the incidence of violence among youths.

In this context, there are two ways to interpret the current mental health movement in juvenile justice. We may look back 20 years from now and see it simply as part of the third reform. Perhaps the pendulum has swung so far toward the criminalization of youths' offenses that an adjustment is needed to moderate the reform's entirely punitive effects. This interpretation is likely to be applied in the future if, looking back to the present decade, we observe that the "tougher" penalties of the third reform remained in place, while being overlaid with refinements in policy to assure that youths with serious mental disorders received needed attention and did not become victims of a one-sided emphasis on punishment.

Alternatively, we may someday conclude that this mental health movement was the beginning of a new era of reform in juvenile justice, not merely an adjustment. As described earlier in this article, many juvenile advocate groups are encouraging the reconstruction of the juvenile justice system to promote sanctions and procedures more in tune with the developmental realities of adolescence.^{19,20,30} Our recent advances in understanding mental disorders of adolescence have been joined by new neuroscience information about brain development in adolescence, as well as behavioral science findings documenting socioemotional differences between adolescents and adults that offer different explanations for

the illegal acts of youths. (For a summary, see Ref. 44.) Together, these advances are providing policy makers with scientific information that asserts in a new way the more philosophical intuition that led to the construction of a juvenile justice system 100 years ago—that adolescents are not adults and that the interests of public safety and justice are better served by a different response to their offenses.

If someday we look back and see that these broader advances in developmental science stimulated a substantial repeal of some of the more punitive laws of the third era, then we may conclude that the "mental health and juvenile justice movement" was not merely an adjustment to existing policies. We may view it, instead, as having been one component in a broader, developmentally sensitive reform that led to a fourth era in the history of the juvenile justice system.

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